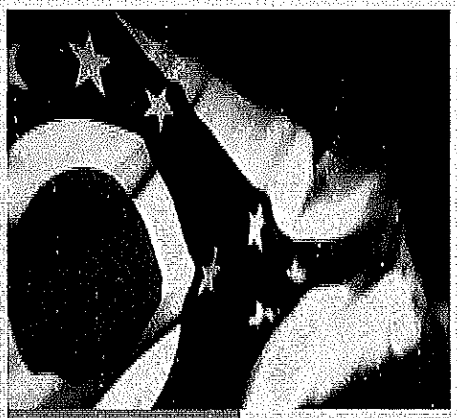
From: Columbus Lawyers Chapter of the Federalist Society
Sent: Monday, December 19, 2016 11:01 AM
To: Lenzo, Mike
Subject: You're invited to Resolved: Keep the FDA Away From My E-Cig (Jan 12, 2017)

Hello ,

You are invited to the following event:

RESOLVED: KEEP THE FDA AWAY FROM MY E-CIG



Event to be held at the following time, date, and location:

Thursday, January 12, 2017 from 12:00 PM to 1:30 PM (EST)

The Athletic Club of Columbus
136 East Broad Street
Columbus, OH 43215

View Map

Share this event:

Resolved: Keep the FDA Away From My E-Cig

The FDA now regulates e-cigarettes. Should it? Will regulation improve public health? Will it cost American lives? Please join us for a lunchtime debate.

Where: Athletic Club of Columbus

When: High noon on January 17, 2017

Arguing for the Resolution:

Jonathan H. Adler

Johan Verheij Memorial Professor of Law

Case Western Reserve University School of Law

Arguing Against the Resolution:

Micah Berman

Assistant Professor of Public Health and Law

The Ohio State University Moritz College of Law

Moderating:

Robert Alt

President and Chief Executive Officer

The Buckeye Institute

The cost is $20 ($15 if you already paid Columbus Lawyers Chapter dues for the 2016-2017 program year, and $5 for students). Lunch is included. R.S.V.P. by *January 10* to guarantee your seat, meal, and pre-printed nametag. Call Ben Flowers at (614) 281-3647 or email ColumbusFedSoc@Gmail.com with any questions. To join or renew your dues for the Columbus Lawyers Chapter, please pay the dues through the Eventbrite website or bring a

check for an additional $25 payable to the Federalist Society.

From: Columbus Lawyers Chapter of the Federalist Society
Sent: Tuesday, December 20, 2016 11:00 AM
To: Lenzo, Mike
Subject: (Corrected) Resolved: Keep the FDA Away From My E-Cig (Jan 12, 2017)

Hello ,

You are invited to the following event:

RESOLVED: KEEP THE FDA AWAY FROM MY E-CIG

Event to be held at the following time, date, and location:

Thursday, January 12, 2017 from 12:00 PM to 1:30 PM (EST)

The Athletic Club of Columbus
136 East Broad Street
Columbus, OH 43215

View Map

Share this event:

(*Correction*: The body of the previous invitation misstated the date of the event. This event will occur on January 12, 2017.)

Resolved: Keep the FDA Away From My E-Cig

The FDA now regulates e-cigarettes. Should it? Will regulation improve public health? Will it cost American lives? Please join us for a lunchtime debate.

Where: Athletic Club of Columbus

When: High noon on January 12, 2017

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Johan Verheij Memorial Professor of Law

Case Western Reserve University School of Law

Arguing Against the Resolution:

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The Ohio State University Moritz College of Law

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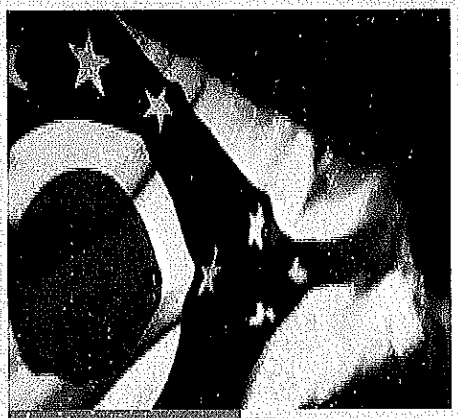
dues through the Eventbrite website or bring a check for an additional $25 payable to the Federalist Society.

From: Columbus Lawyers Chapter of the Federalist Society
Sent: Wednesday, December 28, 2016 11:02 AM
To: Lenzo, Mike
Subject: Reminder to Sign up for Resolved: Keep the FDA Away From My E-Cig (Jan 12, 2017)

You are invited to the following event:

RESOLVED: KEEP THE FDA AWAY FROM MY E-CIG



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Columbus, OH 43215

View Map

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Where: Athletic Club of Columbus

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Case Western Reserve University School of Law

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President and Chief Executive Officer

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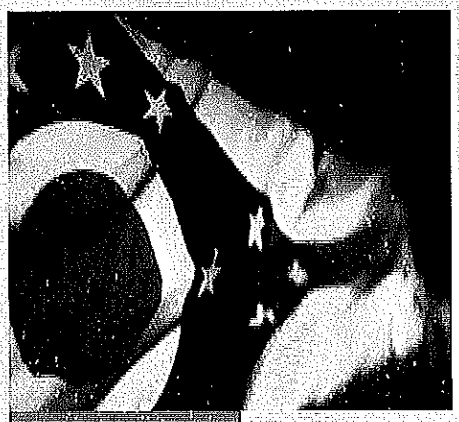
check for an additional $25 payable to the Federalist Society.

From: Columbus Lawyers Chapter of the Federalist Society
Sent: Wednesday, January 4, 2017 6:02 PM
To: Lenzo, Mike
Subject: Sign Up for The Federalist Society's January Event!

You are invited to the following event:

RESOLVED: KEEP THE FDA AWAY FROM MY E-CIG



Attend Event

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Thursday, January 12, 2017 from 12:00 PM to 1:30 PM (EST)

The Athletic Club of Columbus
136 East Broad Street
Columbus, OH 43215

View Map

Share this event:

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Where: Athletic Club of Columbus

When: High noon on January 12, 2017

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Jonathan H. Adler

Johan Verheij Memorial Professor of Law

Case Western Reserve University School of Law

Arguing Against the Resolution:

Micah Berman

Assistant Professor of Public Health and Law

The Ohio State University Moritz College of Law

Moderating:

Robert Alt

President and Chief Executive Officer

The Buckeye Institute

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check for an additional $25 payable to the Federalist Society.

From: Paretti, Dominic
Sent: Monday, January 9, 2017 4:17 PM
To: House_All
Subject: Request for Co-Sponsorship – Paid Parental Leave

Importance: High

Ohio House of Representatives

MEMORANDUM

TO: All House Members
FROM: Representative Janine Boyd
DATE: January 9, 2017
RE: Request for Co-Sponsorship – Paid Parental Leave

I will soon reintroduce legislation to create the Family and Medical Leave Insurance Program. Beginning in 2020, the program will provide 12 weeks of family and medical leave benefits, which will permit individuals to care for a family member, bond with a new child, or address their own serious health condition.

Out of 178 countries worldwide, the United States is one of three that does not provide paid leave to new mothers. Only two states, California and New Jersey, offer paid leave to men and women who provide care. The federal Family Medical Leave Act provides 12 weeks of leave for family and medical reasons. This time is unpaid and employers with fewer than 50 employees are exempt, which eliminates a large segment of workers. Ohio should lead on the issue of paid leave to grow our economy and allow working people to put family first.

The program will be under the purview of the Department of Job and Family Services. An individual would receive leave insurance benefits for: a health condition which makes him/her unable to perform their job duties; caring for a new child during after birth, adoption, or foster care placement; caring for a child, parent, or spouse who has a serious health condition; or the individual is taking any other leave as authorized by the federal Family and Medical Leave Act. In order to be eligible for program benefits, an individual must file a claim with ODJFS; must have worked at least 680 hours during the base period; premiums

have been withheld and remitted for at least one year; and the leave must be for the above-mentioned purposes.

Once established, program benefits will be paid by assessing premiums on employees. Employers will be required to deduct and withhold premiums from employee's wages. However, an employer may opt to pay the contributions on behalf of employees.

An employee who is covered by an employer policy or collective bargaining agreement that provides the employee with greater leave than that provided by the Family and Medical Leave Act may elect not to participate in the Program in accordance with rules adopted by the Director. An employee who elects to opt out of participating in the Program is not liable for any premium or contribution that would otherwise be due under the Program.

Working people in Ohio should not have to worry about losing their job or falling behind financially just to take care of a sick child or relative; address their own serious health condition; or care for and bond with their newborn child. Ohio cities like Dayton and Cincinnati are leading on leave. By allowing working people to put their family first, we can truly make Ohio a better place to live, work, and raise a family.

If you have any questions or would like to co-sponsor this bill, please feel free to contact Dominic Paretti in my office at 4-5079 or Dominic.Paretti@OhioHouse.Gov by 3 pm Friday, January 27, 2017.

Dominic Paretti
Legislative Aide to Representative Boyd
Ohio House District 09
614-644-5079

From: Hucke, Justin
Sent: Friday, January 27, 2017 2:12 PM
To: Hucke, Justin
CC: House_All
Subject: Co-sponsor Request: Online Checkbook

Ohio House of Representatives

To: **All House Members**

From: **Representatives Dever and Greenspan**

Date: **Friday, January 27, 2017**

RE: **Co-sponsor Request: Online Checkbook**

In the near future, we plan to reintroduce legislation that will codify a state government expenditure database. This measure is identical to House Bill 46 of the 131st General Assembly, which **passed the House of Representatives in April of 2015 unanimously with 74 co-sponsors.**

Throughout the legislative process, this legislation had no opponents and attracted broad bipartisan support from organizations including the Buckeye Institute, Ohio Public Research Interest Group, and the Ohio Newspaper Association.

Using existing authority, in December 2014, Ohio Treasurer Josh Mandel unveiled www.ohiocheckbook.com, an easily accessible, searchable database of state expenditures for our taxpayers to hold state government accountable for spending. The new website, arguably the best of its kind in the Nation, reflects the intent of this legislation, but it could readily be taken down by a future treasurer of state. Through this legislation, future treasurers, regardless of political affiliation or commitment to transparency, must maintain this important tool that already is providing more accountable government to our state's residents.

If you would like to co-sponsor this legislation, or if you have any questions or concerns regarding its content, please contact Justin Hucke at 466-8120 or Justin.Hucke@ohiohouse.gov or Bill White at 466-0961 or Bill.White@ohiohouse.gov. **The deadline for co-sponsoring this bill is Friday, February 3rd at 5:00 p.m.**

From: Paretti, Dominic
Sent: Friday, January 27, 2017 4:21 PM
To: House_All
Subject: RE: Request for Co-Sponsorship – Paid Parental Leave

Representative Kristin Boggs has been added as a Joint Sponsor &

CO SPONSOR EXTENDED

Wednesday, February, 8 2017-2 pm

From: Paretti, Dominic
Sent: Monday, January 09, 2017 4:17 PM
To: House_All <House_All@ohiohouse.gov>
Subject: Request for Co-Sponsorship – Paid Parental Leave
Importance: High

Ohio House of Representatives

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DATE: January 9, 2017
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Dominic Paretti
Legislative Aide to Representative Boyd
Ohio House District 09
614-644-5079

From: Hucke, Justin
Sent: Thursday, February 2, 2017 12:32 PM
To: Hucke, Justin
CC: White, Bill
Subject: REMINDER: Co-sponsor Request: Online Checkbook

REMINDER: Deadline to co-sponsor is TOMORROW at 5pm!

Ohio House of Representatives

To: **All House Members**

From: **Representatives Dever and Greenspan**

Date: **Friday, January 27, 2017**

RE: **Co-sponsor Request: Online Checkbook**

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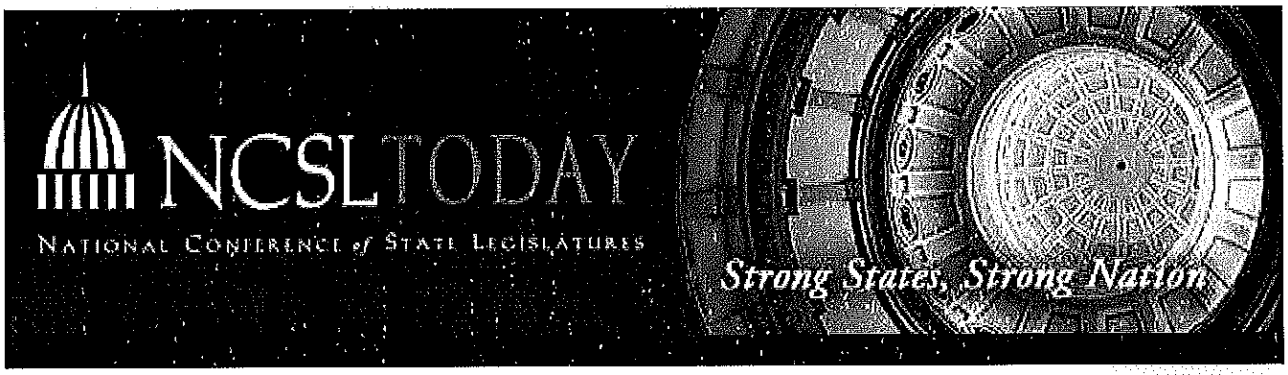
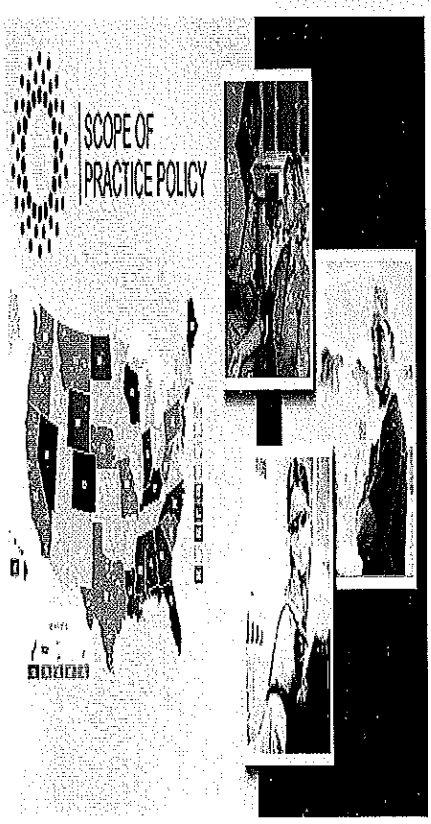
From: NCSL TODAY
Sent: Thursday, February 9, 2017 12:02 PM
To: Lenzo, Mike
Subject: States see favorable conditions for gas tax hike

NCSL Today | Manage your subscription



TOP NEWS Feb. 9, 2017



States see favorable conditions for gas tax hike

Reuters

States where gasoline taxes have not risen in decades are now discussing an increase and conditions might be ripe for the proposed hikes to win approval in state legislatures, tax experts said this week. **NCSL's Kevin Pula quoted.**

North Carolina judges suspend limits on governor's power

The New York Times

A three-judge state court panel in North Carolina on Tuesday held up part of a new Republican-backed law that strips important power from the newly elected Democratic governor.

Legislators question Ohio governor's budget

FEATURED

The Columbus Dispatch

Gov. John Kasich's school-funding proposal, which cuts state aid to rural districts while providing more money for many suburban and urban schools, is getting a mixed reaction from legislators.

= A Iowa Republicans propose sweeping changes to collective bargaining

The Des Moines Register

Republican lawmakers on Tuesday proposed sweeping changes to Iowa's collective bargaining laws that govern the way 184,000 of the state's teachers, corrections officers and other public sector union workers negotiate for wages, health care and other employment benefits.

Congress takes aim at California law mandating retirement plans for low-income workers

The Los Angeles Times

An ambitious California law intended to help create retirement security for low-income workers is in the crosshairs of the Trump-era Congress, which is moving to block the state and others from launching programs to automatically enroll millions of people in IRA-type savings plans.

NCSL Foundation Partnership on Retirement Security.

Universal pre-K is hard to find and harder to fund

Governing

The states and cities expanding early education have

Visit NCSL's new website devoted to Scope of Practice Policy

The purpose of this website is to educate state policymakers about scope of practice issues related to nurse practitioners, physician assistants, dental hygienists and dental therapists.

NEW@NCSL

Three state legislative officers to serve on FCC advisory board

Energy efficiency and renewables in lower-income homes

New edition of Capitol to Capitol newsletter

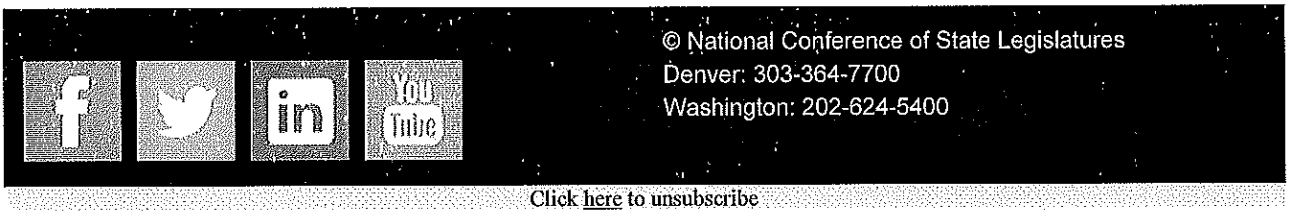
BLOG

Tracking scope of practice around the nation

Different states have different laws regarding scope of practice for health care providers. States define local solutions to local issues surrounding scope of

wrestled with the question of what qualifies as "universal." NCSL research on school readiness and transitions.

practice policy. Tracking what's happening around the country is a challenge. This website provides policymakers with an easy reference source.



= A

7700 East First Place, Denver, CO 80230

From: Springhetti, Blake
Sent: Monday, March 20, 2017 11:35 AM
To: House_All
Subject: Co-Sponsor Request: Exempt State Employees Pay Portion of Dental, Vision, and Life
Attachments: Co-Sponsor Request - Requiring Exempt State Employees to Pay Healthcare Premiums.pdf

Ohio House of Representatives

Representative Derek Merrin

47th District

MEMORANDUM

TO: **All House Members**

FROM: **Representative Derek Merrin**

DATE: **March 20, 2017**

RE: **Co-Sponsor Request: Exempt State Employees Pay Portion of Dental, Vision, and Life Insurance Premiums**

I will be introducing legislation that requires exempt state employees to pay a portion of their dental, vision, and life insurance premiums. Exempt state employees currently pay 15% of their premium for medical insurance – while paying 0% of the premium for dental, vision, and life insurance coverage. This legislation requires exempt state employees pay the same percentage for dental, vison, and life coverage as they pay for their medical insurance premium.

Key Facts:

- By having exempt state employees pay 15% of their dental, vision, and life premiums, taxpayers would save at least $2.6 million annually.

- Legislation would impact about 16,400 exempt state employees.

- Legislation directs the state to seek the same provision when negotiating collective bargaining agreements that cover about 35,900 unionized state employees, which would save taxpayers an additional $4.7 million annually.

If you would like to co-sponsor this legislation or have any questions, please contact my Legislative Aide, Blake Springhetti, at Blake.Springhetti@ohiohouse.gov or at (614) 466-1731 by **Tuesday, March 28 at 5:00 P.M.**

Sincerely,

Ohio House of Representatives

Representative Derek Merrin

47th District

MEMORANDUM

TO: **All House Members**

FROM: **Representative Derek Merrin**

DATE: **March 20, 2017**

RE: **Co-Sponsor Request: Exempt State Employees Pay Portion of Dental, Vision, and Life Insurance Premiums**

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Sincerely,

Derek Merrin
Ohio House of Representatives
House District 47

Office (614) 466-1731
Derek.Merrin@ohiohouse.gov

77 S. High Street
Columbus, Ohio 43215

From: Springhetti, Blake
Sent: Monday, March 27, 2017 11:18 AM
To: House_All
Subject: Reminder: Co-Sponsor Request: Exempt State Employees Pay Portion of Dental, Vision, and Life
Attachments: Co-Sponsor Request - Requiring Exempt State Employees to Pay Healthcare Premiums.pdf

Reminder: The deadline to co-sponsor is tomorrow at 5pm

Ohio House of Representatives

Representative Derek Merrin
47th District
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Derek Merrin
Ohio House of Representatives
House District 47

Office (614) 466-1731
Derek.Merrin@ohiohouse.gov

77 S. High Street
Columbus, Ohio 43215

From: report@hannah.com
Sent: Monday, March 27, 2017 6:51 PM
To: DL_Hannah
Subject: Hannah News Stories for Monday, March 27, 2017

Monday, March 27, 2017

IN TODAY'S HANNAH REPORT:

Please click here to read the entire Hannah Report.

Today's Stories

Hannah News Service, Inc. | 21 W. Broad Street, Suite 1000, Columbus, Ohio 43215 | 614.227.5820 | www.hannah.com

From: Parsons, Jason
Sent: Tuesday, March 28, 2017 3:33 PM
To: Lenzo, Mike
CC: Flasher, Kim; Fleck, Craig
Subject: FW: Updated HR-05 Unauthorized Weapons Policy
Attachments: HR 05 Unauthorized Weapons.pdf

Hi Mike,

Just FYI.

Thank you,

Jason

From: Jessica.Friedhoff@das.ohio.gov [mailto:Jessica.Friedhoff@das.ohio.gov] **On Behalf Of** Michael.Luers@das.ohio.gov
Sent: Tuesday, March 28, 2017 3:25 PM
Subject: Updated HR-05 Unauthorized Weapons Policy

Good afternoon Human Resources Administrators,

State of Ohio Administrative Policy, HR-05 Unauthorized Weapons, has been updated pursuant to Senate Bill 199 which took effect March 21, 2017. The updated policy is attached for your reference. The legislation prohibits an Employer from restricting an individual with a concealed weapon permit from transporting or storing a firearm or ammunition inside the license holder's privately owned motor vehicle.

Pursuant to this change in the law, HR-05 has been updated to permit a concealed weapon permit holder to store or transport their weapon and/or ammunition in their privately owned motor vehicle on property owned or leased by the state where the property is primarily used as a parking facility for motor vehicles (i.e. parking lots and garages), unless otherwise prohibited (e.g. correctional institutions).

The State of Ohio will continue to prohibit individuals from possessing or having under their control, a weapon or other dangerous ordnance (including concealed handguns) while conducting state business or on state time. The policy will continue to prohibit employees or individuals, regardless of whether they possess a concealed carry license pursuant to Revised Code 2923, from carrying or storing a weapon or other dangerous ordnance in a building or

portion of a building owned or leased by the state, in a motor vehicle owned or leased by the state, or when conducting state business or on state time. Employees that have a valid concealed weapon permit are not exempted from the above prohibitions.

Please review the attached policy and model work rule with your agency legal counsel to determine what changes, if any, need to be made to your agency specific policy or work rule. Pursuant to any applicable collective bargaining agreement, changes to your agency work rule(s) may require notice to the union. Please contact your Labor Relations and Human Resources Policy Analyst with any questions regarding union notification and/or changes to HR-05 at dashrd.hrpolicy@das.ohio.gov or 614-752-5393.

Thank you,

Mike

Michael L. Luers
Deputy Director
Human Resources Division
614-728-1327
michael.luers@das.ohio.gov

OhioDAS
SERVICE · SUPPORT · SOLUTIONS
DEPARTMENT OF ADMINISTRATIVE SERVICES

How are we doing?
Please take our brief customer service survey by clicking here.

Ohio Department of Administrative Services
John Kasich, *Governor*
Robert Blair, *Director*

OhioDAS

State of Ohio Administrative Policy

Unauthorized Weapons

No:
Human Resources
HR-05

Effective:
March 28, 2017

Issued By:

Robert Blair, Director

1.0 Purpose

To establish a uniform policy regarding unauthorized weapons and encourage appointing authorities to establish work rules.

A glossary of terms found in this policy is located in Appendix A – Definitions. The first occurrence of a defined term is in ***bold italics.*** To go directly to a term's definition, click on the bold and italicized term. To return to the body of the policy, click on the defined term.

2.0 Policy

The State of Ohio is committed to providing its employees a work environment that is safe and secure. This commitment includes prohibiting employees from possessing or having under their control a ***weapon or other dangerous ordnance*** while conducting state business or on state time, including possession or control of a weapon or other dangerous ordnance in an employee's personal vehicle, unless specifically authorized by the employee's appointing authority or as provided in Section 2.3 below. The state's prohibition against such unauthorized weapons or other dangerous ordnance applies to all contractors and all employees, including but not limited to permanent state employees, contract workers, temporary workers, consultants, college interns, student help, and anyone else conducting business on state property.

2.1 **Prohibited Items:** Any weapon or other dangerous ordnance.

2.2 **Prohibited Conduct:** Employees shall not carry or store a weapon or other dangerous ordnance:

- In a facility, building, or portion of a building owned or leased by the state, including parking lots or garages, except as provided in Section 2.3 below;

- In a motor vehicle owned or leased by the state; or
- While conducting state business or on state time, even when employees are off of state-owned or leased property.

2.3 **Effect of *Concealed Carry License*:** Individuals covered by this policy who have been issued a permit to carry a concealed weapon in the State of Ohio are not exempt from the above provisions. Individuals covered by this policy who carry or possess a weapon must store the weapon in accordance with the law prior to entering an area in which a weapon is prohibited. This section also applies to an active duty member of the armed forces of the United States who meets the requirements under Revised Code Section 2923.126 (E)(2) to have the same right to carry a concealed weapon as a person issued a concealed carry license.

Individuals covered by this policy who have been issued a concealed weapon permit may store or transport their weapon and/or ammunition in their privately owned motor vehicle on property owned or leased by the state that is primarily used as a parking facility for motor vehicles (i.e. parking lots and garages), unless otherwise prohibited. The weapon and/or ammunition must remain inside the person's privately owned motor vehicle while the person is physically present inside the motor vehicle, or the weapon and/or ammunition must be locked in the trunk, glove box, or other enclosed compartment or container within or on the person's privately owned motor vehicle while on the above referenced property owned or leased by the state.

2.4 **Violations:** Violations will be subject to legal action as appropriate. Violation of this policy by a state employee may lead to disciplinary action up to and including termination in accordance with the applicable law, rule, or collective bargaining agreement.

2.5 **Work Rules:** Appointing authorities are encouraged to develop workplace-specific rules in furtherance of this policy. To assist appointing authorities in developing unauthorized weapons work rules, a model work rule is attached.

3.0 Authority

ORC 124.09, 125.831, 2923.11, 2923.1210; 2923.126; OAC 123:1-45-01; 123:1-47-01(B)

This policy supersedes any previously issued directive or policy and will remain effective until canceled or superseded.

4.0 Revision History

Date	Description of Change
09/01/2009	Last issued.
03/28/2017	Reissued in new format and for compliance with SB 199, 131st General Assembly.

5.0 Inquiries

Direct inquiries about this policy to:

Labor Relations and Human Resources Policy Section
Office of Collective Bargaining
Ohio Department of Administrative Services
1602 West Broad Street
Columbus, Ohio 43223

614.752.5393 | DASHRD.HRPolicy@das.ohio.gov

State of Ohio Administrative Policies may be found online at
www.das.ohio.gov/forStateAgencies/Policies.aspx

Appendix A – Definitions

a. Weapon or other dangerous ordnance. Includes but is not limited to all devices listed in 2923.11 of the Revised Code, including firearms except as provided in this policy; a club; brass knuckles; any martial arts weapon; a stun gun; explosives; a bow and/or arrows, including a crossbow; or a knife, other than a small folding knife.

b. Concealed carry license. Concealed carry license, permit to carry a concealed weapon, concealed weapon permit, and concealed carry permit all have the same definition as "concealed handgun license" and "license to carry a concealed handgun" pursuant to Section 2923.11 of the Revised Code.

Appendix B – Resources

Document Name
Attachment 1 – Model Work Rule on Unauthorized Weapons

Model Work Rule on Unauthorized Weapons

1. No (Agency) employee while conducting state business, during working hours, on state time, or while on or in state-owned or leased property, shall possess or have under his or her control, any offensive or defensive weapons, including but not limited to, a firearm (including unloaded, inoperable or sawed off firearms, starter pistols, zip guns, etc.), knife*, club, brass knuckles, martial arts weapon, or stun gun. Dangerous ordnance, incendiary or explosive devices or chemicals, fireworks, or similar items are considered weapons and/or dangerous devices for purposes of this work rule and are prohibited.

2. For purposes of this (Agency) work rule, state-owned or leased property includes but is not limited to, state-owned and/or leased vehicles, state-owned and/or controlled parking facilities or surface lots. Specifically, prohibited items shall not be stored in personal vehicles parked on state-owned and/or leased property. Additionally, weapons shall not be stored in or on state-owned and/or leased property. Refer to HR-04 Workplace Violence Prevention Policy and HR-05 Unauthorized Weapons Policy for additional information.

   Exception – This (Agency) work rule does not apply to (Agency) employees who are required as a condition of their work assignment to possess firearms, weapons, or other dangerous devices and are specifically authorized in writing by the Director to do so, to the extent the employee is possessing such a firearm, weapon, or dangerous device consistent with the employee's work assignment and written authorization. In addition, (Agency) employees who have been issued a permit to carry a concealed weapon in the State of Ohio or who are active duty members of the military with military identification and documentation of successful completion of firearms training that meets or exceeds the requirements for a concealed weapon permit may transport and/or store their firearm and/or ammunition in their personal vehicle while on state-owned and/or leased property. The weapon and/or ammunition must remain inside the person's privately owned motor vehicle while the person is physically present inside the motor vehicle, or the weapon and/or ammunition must be locked in the trunk, glove box, other enclosed compartment or container within or on the person's privately owned motor vehicle while on property owned or leased by the state.

3. An (Agency) employee who violates this work rule or uses or threatens to use any object as a weapon against any person shall be subject to disciplinary action, up to and including removal for the first offense.

4. *A small folding knife is permitted.

5. Nothing in this policy is intended to replace or conflict with state law.

From: Dennis Hetzel
Sent: Wednesday, April 5, 2017 11:33 PM
To: andyalexander1@me.com; Ron Amstutz (FWD external); Mary Amos Augsburger; Carrie Bartunek; sbazzoli@ohionews.org; Timothy J. Bechtold; BEBecker@ohioauditor.gov; putter007@aol.com; mattborges@columbus.rr.com; Rep41; jchabria@mercuryllc.com; sunshinecounsel@gmail.com; mcohen@thebeaconjournal.com; RANDY.COLE@ohioturnpike.org; Mitch Colton; pconkle@adohio.net; David P. Corey; Christopher Crawford; Michael Curtin; rod.davisson@icemiller.com; Frank Deaner; BTD@manleydeas.com; Michael Dew; Walt Dozier; mike.duffey@gmail.com; Heather Dugan; Faber@bright.net; chrissie.thompson@gmail.com; AFiore@keglerbrown.com; MFishel@fishelhass.com; Matthew Forney; Fought@ohiotownships.org; rgardner@wcnet.org; sgeorge@ohiohistory.org; john.gilchrist@oacp.org; Fred Gittes; anne.gonzales@me.com; rgraf@civitasmedia.com; BLHalpin@ohioauditor.gov; Dana S. Hammond; bharmon@dispatch.com; Daniel R. Helmick; Daniel G. Hilson; dlhoeffel@vorys.com; Melissa Hoeffel; djohnson@oft-aft.org; Belinda Jones; Dan Jones; Emmalee.Kalmbach@governor.ohio.gov; joe.andrews@governor.ohio.gov; MKeenan@keenanins.com; mlandes@isaacwiles.com; Sen. Frank LaRose; legerlynnea@gmail.com; Lenzo, Mike; JLeutz@ccao.org; Luther@grafflaw.com; larrylongopg@gmail.com; jim.lynch@governor.ohio.gov; bjmarrison@ohioauditor.gov; Jason Mauk; mjmauer@ohioauditor.gov; John.McClelland@ohiosenate.gov; Mindy McLaughlin; BMead@ccao.org; Christine H. Meritt; Scott Milburn; Edward.Miller@sc.ohio.gov; amiller@dispatch.com; Scott A. Miller; Alan A. Miller; rob@johnkasich.com; mnieporte@athensmessenger.com; Nancy Nussbaum; Kate.Oliphint@columbuszoo.org; Eva Parziale; jperz@itsupportltd.com; dpreisse@vanmeter-ashbrook.com; Erin Rabinowitz; Chip Ramsey; Kathy Redmond; mreed@ohiocourtofclaims.gov; ERhinehart@ficlaw.com; ariggs@ohionews.org; Jason Sanford; ckschneider@hotmail.com; schultz.connie@gmail.com; Jeffrey D. Schwartz; Anthony Seegers; Alexander Lapso; GESpeaks@columbus.gov; frank.strigari@senate.state.oh.us; csubler@ccao.org; tsuddes@gmail.com; mszollosi@actohio.org; Cathy Teets; chairman@ohiogop.org; STugend@keglerbrown.com; Catherine Turcer; Whalen, Jason; Bill@sswlaw.com; Charles R. Wallace; mweinman@fopohio.org; MWhalen@ralaw.com; Erica.Wilson@ohioattorneygeneral.gov; Bret Wiseman; Sen. William Coley; larry.obhof@yahoo.com; teniehaus@vorysadvisors.com
Subject: Invitation to a launch event for Dennis Hetzel's new novel

Dear Columbus-area Friends and Colleagues:

Many of you know me as the executive director of the Ohio News Media Association. I have drawn on my experience as a journalist, media executive, lobbyist, political junkie and obsessive Chicago Cubs fan in my new sports-political thriller, "Season of Lies." The story follows the events in my award-winning debut novel, "Killing the Curse."

The premise: What if there was a presidential candidate with a dark secret that could derail his reelection, put his life at risk and destroy his marriage? What if a star Major League Baseball pitcher became involved in the president's campaign, threatening his own career and the Cubs' chances at a World Series championship?

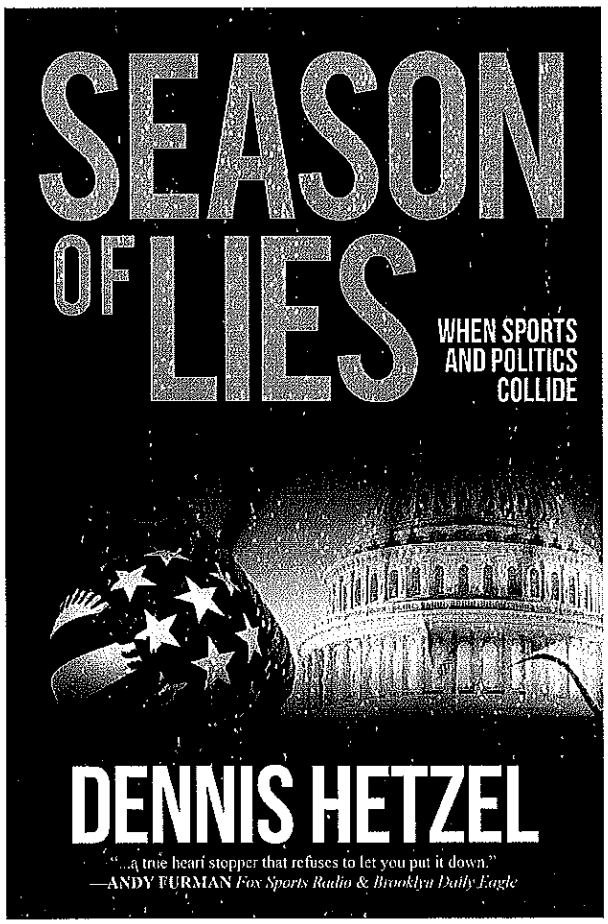
The baseball and political seasons come to a head in "Season of Lies." (Headline Books, Inc.) **I hope you will join me for my official book release party at The Book Loft in Columbus' German Village on Thursday, April 27.**

Author and former *Associated Press* sportswriter Hal Bock calls it "a riveting political thriller that spills over into baseball... an absorbing novel that keeps the reader on edge from start to finish." Andy Furman of Fox Sports Radio describes "Season of Lies" as "a true heart-stopper." Actor Dean Haglund of the "The X-Files" writes, "I love this book. Baseball continues to serve as a literary metaphor, this time in an era of political conspiracy and hyper-religiosity. Mr. Hetzel seems to have so many intriguing fields of interest and his research folds all these seemingly divergent threads into one exciting story."

I look forward to seeing you at The Book Loft, 631 3rd Street, on Thursday, April 27, from 6:30 until 8:00 p.m. For information, call 614-464-1774 or visit www.bookloft.com. I also invite you to learn more about my books at my website, dennishetzel.com, my Facebook author page, or at @DennisHetzel on Twitter.

Thanks for considering!

Dennis Hetzel



From: Shari O'Neill
Sent: Wednesday, May 10, 2017 9:45 AM
To: 'Dennis Mulvihill'; 'Janet Abaray'; 'Kelley Pund'; 'Beth Moore'; 'Roger Beckett'; 'Lisa Ormiston'; Cupp, Bob; Hildabrand, Dorothy; Searcy, Aubrey; Jordan@ohiosenate.gov; Ron Puff; Brian Jewell; 'Vernon Sykes'; 'Vernon@sykes.tv'; Jaehla Meacham; Desmond Bryant; 'Wagoner, Mark D. Jr.'; 'anyers@slk-law.com'; Holmes, Glenn; Glass, Chris; Terese Herhold; Shari O'Neill; Shaunte Russell; Jennie Long; 'Steven H Steinglass'; 'Christopher Gawronski'; Lundregan, Scott; Bethany Sanders; Cherry, Sarah; Jordan Pennell; Lane, Hope; Erich Bittner; Willamowski, Sheila; Lenzo, Mike; Blessing, Heather; Frank Strigari; George Boas
Subject: FW: CRU-Article II Amendments from Sen. Sykes
Attachments: Amendment.RemovingEvenYear.pdf; Amendment.Removing55%.pdf; Amendment.ParityforGeneralAssembly.pdf; Amendment.DeadlineConstitutionalAmendment.pdf; Amendment.DeadlineInitiatedStatute.pdf; Amendment.PetitionRequirementsConflict.pdf; Amendment.TimeframeforAG.PDF

Dear Chair Mulvihill, Vice-chair Kurfess, and Members of the Constitutional Revision and Updating Committee,

I am forwarding correspondence and attachments I just received regarding the proposed changes to the initiative and referendum sections of Article II.

Best regards, Shari

Shari L. O'Neill | Interim Executive Director and Counsel to the Commission
Ohio Constitutional Modernization Commission
77 S. High St., 24th Floor | Columbus, OH 43215
614.644.4801 *phone* | 614.644.9095 *fax*
Shari.ONeill@ocmc.ohio.gov
www.ocmc.ohio.gov

From: Sanders, Bethany [mailto:Bethany.Sanders@ohiosenate.gov]
Sent: Wednesday, May 10, 2017 9:41 AM
To: Shari O'Neill
Cc: Senate_District_28; Terese Herhold; George Boas
Subject: CRU-Article II Amendments from Sen. Sykes

Please see attached for distribution to the committee. As we discussed we will provide the hard copies for committee.

Bethany E. Sanders
Legal Counsel
Ohio Senate Democratic Caucus
bethany.sanders@ohiosenate.gov
(614) 466-0637

Removing the even year requirement.

Language change:

In Section 1a(F) at the top of page 4; delete "in an even-numbered year".

In Section 1a(G) on page 4 of the circulated draft, change "at the next general election held in an even-numbered year." To "at the next general election."

Effect:

This adjustment would mean that any petition filed by the annual deadline would be placed on the next general election ballot in any year.

Rationale:

While voter turnout should always be included, the long gaps between when amendments could be adopted are a barrier to citizen voices and participation. In addition, the costs of running a campaign (in favor or in opposition) in even year general elections is much greater than in odd-year elections giving an advantage to moneyed interests in pursuing an initiative.

Removing the 55% requirement.

Language change:

In Section 1a(H) on page 4 of the circulated draft, change "approved by at least 55 percent of the electors voting" to "approved by a majority of the electors voting"

In Section 1a(I) on page 4 of the circulated draft, change "approved by at least 55 percent of the electors voting" to "approved by a majority of the electors voting".

Effect:

This amendment would return the proposal to current law requiring a simple majority of those voting to approve a constitutional amendment proposed by initiative.

Rationale:

An increased passage threshold is not needed. Voters reject more proposed amendments then they adopt and should be trusted without special hurdles.

Aligning the requirements for an initiated amendment with those for a General Assembly proposed amendment.

Language Change:

Add to the report and recommendation a proposed amendment to Article XVI of the Ohio Constitution as follows [current law in plain text, deleted language struck, new language underlined].

XVI.01 How constitution to be amended; ballot; Supreme Court to hear challenges

Either branch of the General Assembly may propose amendments to this constitution; and, if the same shall be agreed to by three-fifths of the members elected to each house, such proposed amendments shall be entered on the journals, with the yeas and nays, and shall be filed with the secretary of state ~~at least ninety days before the date of the election at which they are to be submitted to the electors, for their approval or rejection~~. The proposed amendments shall be submitted to the electors as if they were proposed by initiative pursuant to Article II, Section 1a(F) and 1a(G). They shall be submitted on a separate ballot without party designation of any kind~~, at either a special or a general election as the General Assembly may prescribe~~.

The ballot language for such proposed amendments shall be prescribed by a majority of the Ohio ballot board, consisting of the secretary of state and four other members, who shall be designated in a manner prescribed by law and not more than two of whom shall be members of the same political party. The ballot language shall properly identify the substance of the proposal to be voted upon. The ballot need not contain the full text nor a condensed text of the proposal. The board shall also prepare an explanation of the proposal, which may include its purpose and effects, and shall certify the ballot language and the explanation to the secretary of state not later than seventy-five days before the election. The ballot language and the explanation shall be available for public inspection in the office of the secretary of state.

The Supreme Court shall have exclusive, original jurisdiction in all cases challenging the adoption or submission of a proposed constitutional amendment to the electors. No such case challenging the ballot language, the explanation, or the actions or procedures of the General Assembly in adopting and submitting a constitutional amendment shall be filed later than sixty-four days before the election. The ballot language shall not be held invalid unless it is such as to mislead, deceive, or defraud the voters.

Unless the General Assembly otherwise provides by law for the preparation of arguments for and, if any, against a proposed amendment, the board may prepare such arguments.

Such proposed amendments, the ballot language, the explanations, and the arguments, if any, shall be published once a week for three consecutive weeks preceding such election, in at least one newspaper of general circulation in each county of the state, where a newspaper is published. The General Assembly shall provide by law for other dissemination of information in order to inform the electors concerning proposed amendments. An election on a proposed constitutional amendment submitted by the general assembly shall not be enjoined nor invalidated because the explanation, arguments, or other information is faulty in any way. If ~~the majority of the electors voting on the same shall adopt such amendments~~ adopted pursuant to the procedure in Article II Section 1a(H) and 1a(I) the same shall become a part of the constitution. When more than one amendment shall be submitted at the same time, they shall be so submitted as to enable the electors to vote on each amendment, separately.

XVI.03 Question of constitutional convention to be submitted periodically

At the general election to be held in the year one thousand nine hundred and thirty-two, and in each twentieth year thereafter, the question: "Shall there be a convention to revise, alter, or amend the constitution[,]" shall be submitted to the electors of the state; and in case a majority of the electors, voting for and against the calling of a convention, shall decide in favor of a convention, the General Assembly, at its next session, shall provide, by law, for the election of delegates, and the assembling of such convention, as is provided in the preceding section~~; but no amendment of this constitution, agreed upon by any convention assembled in pursuance of this article, shall take effect, until the same shall have been submitted to the electors of the state, and adopted by a majority of those voting thereon~~. Any amendments proposed by the convention shall be submitted to and approved by the electors as if they were proposed by initiative pursuant to Article II, Section 1a(F), 1a(G), 1a(H), and 1a(I).

Effect:

This language, by cross referencing the Article II provisions would place the same procedure on general assembly proposed amendments and constitutional convention proposed amendments as initiative proposed amendments in three key ways: the timing of when it can appear; the votes needed for adoption; and the syncing of effective dates 30 days after approval.

Rationale:

The citizens' right to initiative should be considered equal to the General Assembly's ability to amend. This means they should be subject to the same requirements. The 30-day effective date is both for fairness and practicality if the amendment requires any preparation, adjustment, or notice to citizens after passage.

Annual Deadline to File a Proposed Constitutional Amendment

Language:

Within section 1a(F) at the top of page 4, replace "June" with "July"

Effect:

Delays by one month the deadline for an initiated constitutional amendment to appear at the next available election.

Rationale:

Under current law, initiated amendments must be filed at least 125 days before next general election. This always falls in early July. It is appropriate to avoid undue delay in when a certified question is placed before the voters. In addition, moving the title and ballot language process to the front end will simplify what needs to occur after certification and before an issue is submitted to the voters.

Annual Deadline to File a Proposed Initiated Statute

Language:

Within section 1b(F) on page 6 and the top of page 7 replace each "February" with "April".

Within section 1b(H) on page 7 replace "June" with "July".
Effect:

Delays by two months the deadline for an initiated statute to appear at the next available election and delays by one month the deadline for the General Assembly to act or the petition to be withdrawn.

Rationale:

This amendment is supportive of the goal of making the initiated statute more attractive as compared to the constitutional amendment. The General Assembly will still have 3 months on which to work on the proposal before it is placed on the ballot. It is appropriate to avoid undue delay in when a certified question is placed before the voters. This still leaves more than 125 days for preparation for the issue to be presented to electors.

Petition Requirements Conflict Correction

Language Change:

Within Section 1d (A) on page 11 after "a full and correct copy of the" strike the remainder of the sentence "summary approved by the attorney general." And insert "title and ballot language prescribed by the ballot board."

Effect:

This amendment creates consistency between 1d(A) which deals only with petition requirements and 1a(C)(2), 1b(C)(2), and 1c(E)(1) which require the ballot language to be printed as part of the petition and explicitly state no other summary is required. 1d(A) without this amendment directly conflicts with that provision.

Rationale:

Since the ballot language is what electors will be met with in the booth, it makes sense to have the ballot language be part of the petition process. Nothing in the amendment would preclude circulators from sharing the attorney general approved summary with electors.

Adding timeframe for Attorney General Action

Language Change:

Within Section 1a (B)(1) on page 2 after the word "shall" insert ", within ten days, ".

Within Section 1b(B)(1) on page 5 after the word "shall" insert ", within ten days, ".

Effect:

Establishes a timeframe for the Attorney General to review a submitted initiated constitutional amendment or initiated statute to determine if it is sufficient and if the summary is a fair and truthful statement. The 10-days suggested in this amendment aligns with current law and the language for review of a referendum petition in 1c.

Rationale:

A time frame for review is important to protect the rights of petitioners. Under current law the requirement is 10 days and though there are reasonable scheduling rational to extend the ballot board review timeframe to 14 days, no such reason exists for Attorney General Review. This amendment creates consistency within the recommended new language and avoids unintended changes to current law.

From: Parsons, Jason
Sent: Thursday, May 11, 2017 11:50 AM
To: House_All
Subject: Open Enrollment 2017!
Attachments: 2017-2018 Pathways Open Enrollment.pdf; Open Enrollment 2017.ppsx

Importance: High

Open Enrollment 2017 will take place May 15 through May 26, 2017. All changes made during open enrollment will take effect July 1, 2017 and remain effective through June 20, 2018.

Please read the information listed below, along with the attached power point, as they outline changes for the upcoming benefit year!

Medical & Pharmacy

- Medical deductibles will be $250 for single and $500 for family in-network, and $500 for single and $1,000 for family out-of-network.
- The copay for an emergency room visit will be $100, which is waived if patient is admitted as inpatient.
- The copays for urgent care will be $30 for in-network and $35 for out-of-network.
- The copay for specialist visits will be $25 for in-network.
- The out-of-pocket maximums for pharmacy benefits will be $2,500 for single and $5,000 for family.

Take Charge! Live Well!

- Employees and spouses enrolled in the State of Ohio medical plan can earn up to $350 each again this year by taking the required actions to improve your health. However, some new criteria have been implemented to receive your reward.

Healthways

- Beginning July 1, 2017, due to new federal regulations, Healthways, the wellness program's third-party administrator, will require either written or online approval to access the program via Well-Being Connect®, Healthways' online portal for State of Ohio employees and spouses. Personal information on the Healthways portal is protected and confidential. Healthways does not share information or use

information against the terms and conditions of the contract with the State of Ohio.

Below is the link to the DAS website for open enrollment:

http://www.das.ohio.gov/OpenEnrollment

IF YOU DO NOT HAVE A CHANGE IN STATUS OR DEPENDENTS, YOU DO NOT NEED TO DO ANYTHING DURING OPEN ENROLLMENT.

If you prefer to review a hard copy of the Pathways to Open Enrollment, there are copies available in the 12th floor administrative office. Feel free to contact me regarding any questions or concerns with the 2017 Open Enrollment.

Jason Parsons
Payroll & Benefits Officer
Ohio House of Representatives
(614) 466-2114


OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES AND THE JOINT HEALTH CARE COMMITTEE
MyBenefits
FOR STATE OF OHIO EMPLOYEES
MEDICAL
PRESCRIPTION DRUG
BEHAVIORAL HEALTH
WELLNESS
DENTAL & VISION
LIFE INSURANCE
2017 OPEN ENROLLMENT
MAY 15-26
OhioDAS
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2017 Benefits Overview

Welcome to the 2017 Open Enrollment edition of MyBenefits magazine. The purpose of this edition is to inform you and your family about the State of Ohio's employee health care benefits available this coming benefit year, which begins July 1, 2017.

Eligible employees can elect to enroll or disenroll themselves and/or their dependents in medical, dental, vision and supplemental life insurance coverage during the Open Enrollment period, which is being held Monday, May 15 through Friday, May 26.

If you already are enrolled in benefits, please review your Benefits Summary by logging into *myOhio.gov* and clicking the myBenefits button to access the benefits information for you as well as your dependents, if applicable. Ensure your dependents still meet the eligibility requirements by visiting *das.ohio.gov/EligibilityRequirements*. If you do not have any changes to your coverage, no additional action is required.

If you wish to waive your current health coverage, you will need to do so during Open Enrollment.

Important Changes for the Upcoming Benefit Year

- Medical deductibles will be $250 for single and $500 for family in-network, and $500 for single and $1,000 for family out-of-network.
- The copay for an emergency room visit will be $100, which is waived if patient is admitted as inpatient.
- The copays for urgent care will be $30 for in-network and $35 for out-of-network.
- The copay for specialist visits will be $25 for in-network.
- The out-of-pocket maximums for pharmacy benefits will be $2,500 for single and $5,000 for family.
- ***Take Charge! Live Well!*** – Employees and spouses enrolled in the State of Ohio medical plan can earn up to $350 each again this year by taking the required actions to improve your health. However, some new criteria have been implemented to receive your reward. Please see the Wellness Rewards chart on Page 13.
- **Healthways** – Beginning July 1, 2017, due to new federal regulations, Healthways, the wellness program's third-party administrator, will require either written or online approval to access the program via Well-Being Connect®, Healthways' online portal for State of Ohio employees and spouses. Personal information on the Healthways portal is protected and confidential. Healthways does not share information or use information against the terms and conditions of the contract with the State of Ohio.

  The Well-Being Connect portal for employees and spouses has been redesigned for a fresh, new look and a better user experience. Healthways will be performing updates from July 1 through July 17. During this time, Well-Being Connect will not be accessible.

OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES STAFF

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- GRAPHIC DESIGN -
TRACE HULL

MyBenefits

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SAVE THE DATES

2017

May
- Open Enrollment begins May 15
- Open Enrollment ends May 26

June
- Benefit year ends June 30

July
- New benefit year begins July 1

October
- Flexible Spending Accounts Open Enrollment for 2018 begins Oct. 16
- Flexible Spending Accounts Open Enrollment ends Oct. 27

December
- Use your remaining Flexible Spending Accounts money by Dec. 31

2018

January
- New Flexible Spending Accounts plan year begins Jan. 1

February
- National Wear Red Day is Feb. 3

March
- 2017 Flexible Spending Accounts claims deadline is March 31

Benefits Eligibility

All eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision or supplemental life insurance for themselves or their dependents can only do so during Open Enrollment, held from Monday, May 15 through Friday, May 26.

All choices made during Open Enrollment will become effective July 1, which begins the new benefit year. You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Annual Open Enrollment unless you experience a change in status/qualifying event, such as marriage, divorce, or the birth or adoption of a child.

For more information about qualifying events:

1. Go to *das.ohio.gov/benefits*;
2. Click on the link for the **Change in Status/Qualifying Events Matrix** along the right navigation pane.

ELIGIBILITY FOR BENEFITS: EMPLOYEES

- Medical – All permanent state employees are eligible to enroll in medical coverage (which includes prescription drug, behavioral health and wellness benefits) during Open Enrollment. Changes made during Open Enrollment are effective July 1. For more information about the eligibility of non-permanent employees pursuant to the Patient Protection and Affordable Care Act, please see *das.ohio.gov/EligibilityRequirements*.
- Dental and Vision – Permanent exempt and union-represented employees are eligible to enroll in dental and vision coverage effective the first day of the month after completing one full year of continuous state service or thereafter during Open Enrollment.
- Basic Life – Permanent exempt and union-represented employees are eligible for basic life coverage after completing one full year of continuous state service. Enrollment is automatic. The exempt employees' basic life insurance benefit is provided through Minnesota Life, a Securian company.
- Supplemental Life – Permanent exempt and union-represented employees are eligible for supplemental life coverage on their date of hire and have 90 days to enroll.* Permanent exempt and union-represented employees also may enroll or make changes during Open Enrollment. The exempt employees' supplemental life insurance benefit is provided through Minnesota Life.

*Certain new enrollments or increases are subject to evidence of insurability and may delay the effective date of coverage.

ELIGIBILITY FOR BENEFITS: DEPENDENTS

- Medical – Dependents are eligible for medical coverage up to the age of 26. Coverage may be continued if the dependent qualifies as a disabled dependent or elects coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Dental and Vision – Dependents are eligible for dental and vision coverage up to age 18 without student status verification. Dependents between the ages of 19 and 23 are eligible for continued coverage as long as they maintain their student status. Student coverage is not automatic; employees are required to submit proof of eligibility within 31 days of the qualifying event. To initiate or continue coverage for your dependent, the employee is required to complete and return an "Affidavit of Student Status" form, accessed at *das.ohio.gov/forms* in the "Eligibility" section. In addition, a "Current Enrollment Verification Certificate" from the National Student Clearinghouse, *studentclearinghouse.org*, or a letter or official transcript from the school registrar must be submitted with the Affidavit of Student Status. If the proof of eligibility is provided timely, the dependent may continue on the coverage until he/she turns 23, when the dependent no longer meets the eligibility requirements, or the dependent is turning 23 and qualifies as a disabled dependent.

To view the detailed eligibility and enrollment requirements for dependents for medical, dental and vision, visit: *das.ohio.gov/EligibilityRequirements*.

Note: To ensure that dependent documentation is processed prior to July 1, it is recommended that employees submit all required eligibility documentation for dependents to your agency human resources office by June 1. The final deadline to submit all required documentation is July 31.

- Basic Life – Dependents are not eligible to enroll in exempt basic life coverage; however, they are permitted to be designated as an employee's beneficiary.
- Supplemental Life – Dependents are eligible for exempt supplemental life coverage. Supplemental life insurance provides up to $40,000 coverage for your spouse; $10,000 in coverage is available without evidence of insurability during Open Enrollment. If you apply for more than $10,000 in coverage for your spouse, Minnesota Life will mail a medical questionnaire to you that must be completed and returned.

  Supplemental life insurance in the amount of $7,000 for each child from birth until age 26 is available for a single monthly premium of .82 cents, regardless of how many children you cover.

  To elect supplemental life insurance for your dependents, you must be enrolled in supplemental life insurance for yourself.

To view the detailed eligibility and enrollment requirements for dependents for exempt basic and supplemental life insurance, visit: *das.ohio.gov/lifeinsurance*.

Eligibility for Benefits

DEPENDENT CATEGORY	MEDICAL	DENTAL	VISION	SUPPLEMENTAL LIFE
Children younger than age 23	Coverage available for eligible dependents[1]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents

[1] View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

[2] Student verification is needed for dependents age 19 to age 23. View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

Note: When one of your enrolled dependents is, or becomes, ineligible for benefits coverage based on the state's definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through COBRA (continuation coverage) if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event.

Enrollment or continuation of enrollment of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims. If you fail to remove a dependent from coverage within 31 days of a qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

Benefits Enrollment Instructions

To enroll, disenroll or make changes, please follow the steps below:

1. Review information about available benefits by carefully reading this Open Enrollment edition of *MyBenefits*. If you have questions, contact your agency benefits representative in your human resources office or the Ohio Department of Administrative Services' HR Customer Service desk at 800-409-1205, select option 2.
2. Enroll in medical, dental and vision coverage or make changes to your or your dependents' current coverage by going online to *myOhio.gov* or by obtaining a paper form.

A. Online

- Go to *myOhio.gov*. Enter your State of Ohio User ID and password. If you have forgotten your State of Ohio User ID or password, contact the OAKS Helpdesk by calling toll-free, 1-888-OHIO-OAK (1-888-644-6625), or in Columbus, 614-644-6625. Make sure to select option 1 when prompted;
- Click on **myBenefits** under Self Service Quick Access on the right side of the page;
- Your Benefits Summary page will open; review your current benefit information;
- Click on **Enroll in Benefits and make the necessary changes or updates.**
  - Submit your enrollment or changes. **All transactions must be completed, submitted and confirmed prior to 7 p.m. Friday, May 26.The system will not accept any entries after 7 p.m. Friday, May 26.** Make sure your online changes are correctly submitted by clicking the **SUBMIT** button on the last two pages of the process. At the end, you will receive a confirmation message that can be printed for your records.
    - For detailed instructions on how to enroll or disenroll online, go to: *das.ohio.gov/EnrollmentInstructions.*
    - Online Open Enrollment is available Monday, May 15 through Friday, May 26, 2017, as follows:

      Weekdays – All day except 7 to 9 p.m.
      Saturdays – All day except 4 to 6 p.m.
      Sundays – All day except 4 p.m. to midnight

B. Paper

- For medical coverage for all eligible employees and dental and vision coverage for exempt employees, obtain a paper State of Ohio Benefit Enrollment/Change Form (ADM 4717) on the Benefits Administration website at: *das.ohio.gov/HealthCareForms* or from your agency's human resources office.
- For all bargaining unit members, forms to change dental and vision coverage are available at *benefitstrust.org* Click the **Forms & Info** link.
- Submit your enrollment or changes by giving your completed and signed State of Ohio Benefit Enrollment/ Change Form (ADM4717) and/or the Union Benefits Trust Dental & Vision Enrollment Form to your agency's human resources office by **4 p.m. Friday, May 26.**

Following Open Enrollment, **all eligible employees will receive a confirmation letter in the mail.** This letter should arrive **in early June.** Please review this letter carefully to ensure your enrollment elections have been processed correctly.

IMPORTANT

If you are enrolling for the first time and/or adding new dependents during this Open Enrollment, you must provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at *das.ohio.gov/EligibilityRequirements*.

Coverage will not be provided for dependents until the eligibility documents are received and approved. The final deadline to submit all required documentation is July 31.

You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Open Enrollment period unless you experience a change in status/qualifying event.

Medical Benefits

The State of Ohio contracts with Aetna, Anthem and Medical Mutual of Ohio to serve as the third-party administrators for the Ohio Med Preferred Provider Organization (PPO). The plan design is the same for all three third-party administrators. Under this plan, employees have access to both network and non-network providers.

Aetna, Anthem and Medical Mutual each serve specific regions in Ohio based on home ZIP codes. You are assigned your third-party administrator based on the first three digits of your home ZIP code. Review the chart on the right that features the ZIP code breakdown by plan administrator. Employees whose home address is outside Ohio are automatically enrolled in Anthem.

For deduction information, see the charts on Page 9.

When you are enrolled in medical coverage, you automatically gain prescription drug, behavioral health and wellness benefits. Medical copayments, deductibles and co-insurance are combined with your behavioral health plan. If you receive medical services prior to meeting your deductible, you may need to pay for these services up to the deductible amount before the plan starts paying. (This does not apply to routine office visits for which you only pay an office visit copayment.)

TO OBTAIN INFORMATION FROM YOUR THIRD-PARTY ADMINISTRATOR:

If you would like to receive information about the plan, providers and ancillary programs from your assigned third-party administrator – Aetna, Anthem or Medical Mutual – refer to the Health and Other Benefits Contacts information on Page 17. You can visit your third-party administrator's website to download and print the information or call their customer service unit to request that it be mailed to you.

Medical Third-Party Administrator ZIP Code Chart

Aetna Plan/Network: Aetna Choice POS II (Open Access)	3-Digit ZIP Code Columbus, Toledo			
	430	431	432	433
	434	435	436	448
	449			

Anthem Plan/Network: Blue Access (PRO)	3-Digit ZIP Code Cincinnati, Dayton Southern Ohio, Springfield Youngstown, Out of State			
	437	438	439	444
	445	450	451	452
	453	454	455	456
	457	458		

Medical Mutual of Ohio Plan/Network: OhioMed	3-Digit ZIP Code Akron, Cleveland			
	440	441	442	443
	446	447		

SAVE MONEY: USE BENEFITS WISELY

All of the State of Ohio's health plans are self-funded. This means that the cost of your benefits is funded by contributions from you and your agency. All claims are paid for from contributions – your third-party administrator does not pay for your claims. Rather, Aetna, Anthem and Medical Mutual review claims and process payments, and are paid an administrative fee. When the amount of paid claims is greater than the amount of contributions from employees and agencies, medical costs go up.

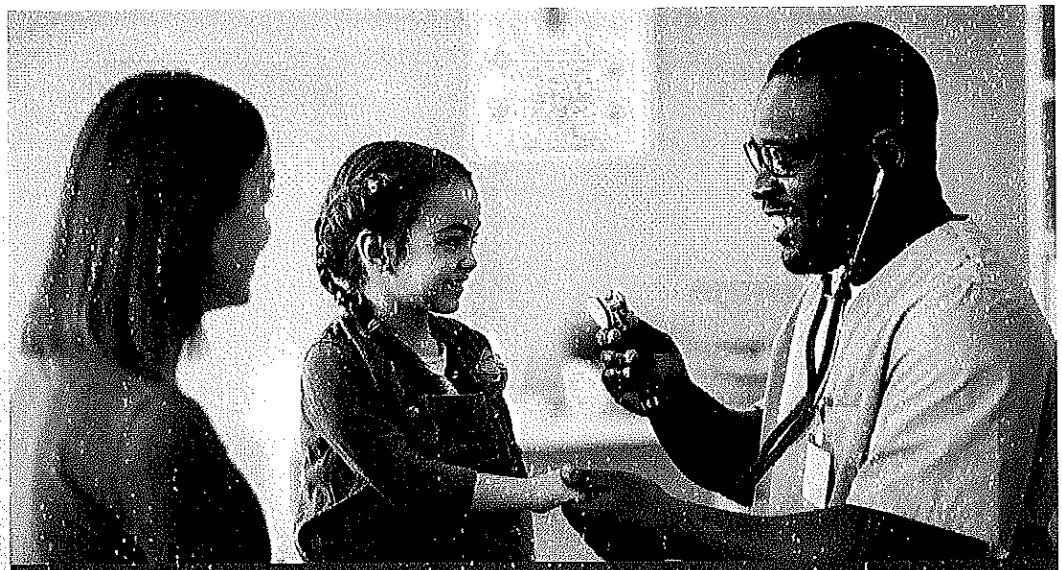
It is up to each of us to use our benefits wisely. We can all do our part by making wellness a priority in our lives, evaluating our options when we need care and avoiding unnecessary visits.

Take advantage of consumer tools provided by our medical third-party administrators that will enable you to shop and find lower costs for the services they provide (MRIs, labs, surgeries, etc.).

Ohio Med PPO

OUT-OF-POCKET COSTS	
Annual Deductible	$250 single, $500 family in-network; $500 single, $1,000 family (combined with behavioral health) out-of-network.
Your Copayments (Office Visits)	Primary care physician: $20 in-network, $30 out-of-network; Specialist: $25 in-network: $30 out-of-network.
Coinsurance	You pay 20%, plan pays 80% in-network; you pay 40%, plan pays 60%[1] out-of-network.
Your Out-of-Pocket Maximum [2]	$1,500 single, $3,000 family in-network; $3,000 single, $6,000 family[3] (combined with behavioral health) out-of-network.
BENEFIT/SERVICE	**COVERAGE LEVELS**
Chiropractic Care	• Covered at 80% in-network; 60% out-of-network. • Unlimited visits (review required).
Diagnostic, X-Ray and Lab Services	• Covered at 80% in-network; 60% out-of-network.
Durable Medical Equipment	• Covered at 80% in-network; 60% out-of-network.
Emergency Room	• Covered at 80%; $100 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency.
Hearing Loss[5] (Accidental, Injury or Illness)	• Covered at 80% in-network; 60% out-of-network. • Hearing aids, exams and follow-ups are included in coverage.
Home Health Care	• Covered at 80% in-network; 60% out-of-network; limit of 180 days.
Hospice Services	• Covered at 100% with no copay, time or dollar limitations for both in- and out-of-network.
Immunizations	• Most are covered at 100% in-network; 60% out-of-network.[4]
Infertility Testing	• Covered at 80% after applicable copay, for in-network; 60% after $30 copay out-of-network. • Coverage includes testing only.
Inpatient and Outpatient Services	• Covered at 80% in-network; 60% out-of-network.
Maternity - Delivery	• Covered at 80% in-network; 60% out-of-network.
Maternity - Prenatal/ Postpartum Care	• Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in-network; 60% out-of-network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%.
Physical, Occupational and Speech Therapy	• Covered at 80% in-network; 60% out-of-network. • Unlimited visits (review required). • Includes coverage for Autism Spectrum Disorder.
Preventive Exams and Screenings	• Most preventive care covered at 100% in-network; 60% out-of-network. • Age restrictions may apply.
Skilled Nursing Facility	• Covered at 80%; 180-day limit, additional days covered at 60% for both in- and out-of-network.
Urgent Care	• $30 copay in-network; $35 copay out-of-network. • Covered at 80% in-network; 60% out-of-network.

[1] Plan pays 60% of Ohio Med PPO's contracted allowable amount and you pay any remaining balance.
[2] For prescription drug out-of-pocket cost information, see chart on Page 11.
[3] If your out-of-network charge is greater than the Ohio Med PPO contracted allowable amount, your out-of-pocket costs will be more.
[4] For a list of immunizations paid at 100 percent, see Page 10.
[5] Hearing aids for natural hearing loss are covered at 50%, up to $1,000 lifetime maximum.



FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY PAID EMPLOYEE DEDUCTIONS[1]			FULL-TIME / MONTHLY PAID EMPLOYEE DEDUCTIONS[1]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$46.19	$260.64	$306.83	$100.07	$564.75	$664.82
Family Minus Spouse	$126.44	$715.40	$841.84	$273.94	$1,550.02	$1,823.96
Family Plus Spouse[2]	$132.21	$715.40	$847.61	$286.44	$1,550.02	$1,836.46

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS[1] 50% TIER			PART-TIME BIWEEKLY DEDUCTIONS[1] 0% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$153.41	$153.42	$306.83	$306.83	$0.00	$306.83
Family Minus Spouse	$420.92	$420.92	$841.84	$841.84	$0.00	$841.84
Family Plus Spouse[2]	$426.69	$420.92	$847.61	$847.61	$0.00	$847.61

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

Preventive Care

STAY HEALTHY, SAVE MONEY

Preventing and detecting disease early is important to living a healthy life. The better your health, the lower your health care costs are likely to be. One of the most important actions you can take for your health and your family's health is to schedule regular check-ups and screenings with your primary care physician.

Your State of Ohio medical plan offers the following services with no deductible, no copayment and no coinsurance for network providers. Other services are available for the normal copayment, coinsurance and deductible amounts.

FREE EXAMS AND SCREENINGS	
Clinical breast exam	1/plan year
Colonoscopy	Every 10 years starting at age 50
Flexible sigmoidoscopy	Every 10 years starting at age 50
Glucose	1/plan year
Gynecological Exam	1/plan year
Hemoglobin, hematocrit or CBC	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Mammogram	1 routine and 1 medically necessary/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
Stool for occult blood	1/plan year
Urinalysis	1/plan year
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21
Well-person exam (annual physical)	1/plan year

FREE IMMUNIZATIONS	
Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2/4/6/12-15 months
Hepatitis A (HepA)	2 doses between 1-2 years
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Human Papillomavirus (HPV)	3 doses for 9-26 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Rotavirus (Rota)	2/4/6 months
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for susceptible adults
Zoster (shingles)	1 dose for age 19 and older

This is not an all-inclusive list. Please refer to das.ohio.gov/medical for more information about preventive care services.

Prescription Drug

OptumRx provides prescription drug benefits for State of Ohio employees and their dependents who are enrolled in the Ohio Med PPO Plan.

Not all drugs are covered

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include medications used for heartburn, glaucoma, multiple sclerosis, diabetes, asthma, elevated triglycerides, migraines, osteoporosis, nasal allergies, sleep disturbances and high blood pressure as well as atypical antipsychotics and antiviral medications such as Valtrex®. Additional medications requiring step therapy may be added at any time. If this occurs, members currently using the affected drugs will be notified in advance by mail.

A program description and a list of medications are on the Benefits Administration website, *das.ohio.gov/prescriptiondrug*, under **"Prescription Drug Updates."**

Diabetes Management Program

Members are eligible for free medication and diabetic supplies if they have had a hemoglobin A1C test within the past 12 months of being a member of the Ohio Med PPO.

Website offers online tracking, tools

The website for OptumRx, *OptumRx.com*, is a private, secure website. All of your pharmacy plan information is available at your fingertips 24/7.

Easy access to the OptumRx website allows you to:

- Compare mail-order prices and prices at local pharmacies;
- Find your lowest copay;
- Locate your pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order; and
- Learn more about your prescription drugs.

Visit *OptumRx.com* today. You will need your pharmacy member ID number located on your OptumRx card to log in. The number begins with the letter "A." For questions, contact OptumRx at 866-854-8850.

Specialty drug management program

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from the specialty pharmacy, Briova, and can only be filled for 30 days or less. Your order may be shipped to your home or workplace. A description of the program and a list of specialty medications are available on the Benefits Administration website at *das.ohio.gov/prescriptiondrug* under the **"Specialty Drug List."**

COPAYMENT COSTS

TYPE OF MEDICATION	30-DAY SUPPLY AT RETAIL COPAYMENT	30-DAY SUPPLY SPECIALTY COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL-ORDER COPAYMENT
Generic	$10	$10	$30	$25
Preferred Brand-Name	$25	$25	$75	$62.50
Non-Preferred Brand-Name, Generic Unavailable	$50	$50	$150	$125
Non-Preferred Brand-Name, Generic Available	$50 plus the difference between the cost of the brand-name and generic drug	$50 plus the difference between the cost of the brand-name and generic drug	$150 plus the difference between the cost of the brand-name and generic drug	$125 plus the difference between the cost of the brand-name and generic drug
Out-of-Pocket Maximum*	$2,500 single/$5,000 family			

The amount charged to the individual for generic, preferred brand and non-preferred brand medications will not be greater than the actual cost of the medication. Therefore, the amount charged may be less than the flat-dollar copay.

The maximum copay for oral oncology medications will be $100 for a 30-day supply. For more details, visit das.ohio.gov/prescriptiondrug.

*** Pharmacy copays do not apply toward medical/behavioral health plan deductibles and the annual out-of-pocket maximum.**

Behavioral Health

HELP AVAILABLE 24/7

Optum Behavioral Solutions provides specialized behavioral health and substance use services for State of Ohio employees and their dependents who are enrolled in the Ohio Med PPO. This program provides 24-hours-a-day, seven-days-a-week confidential phone assessment and referral services for a variety of behavioral health issues, such as:

- Anger management;
- Anxiety;
- Compulsive disorders;
- Depression;
- Marital and family issues;
- Serious mental illness;
- Stress; and
- Substance use disorders.

Copayments, deductibles and co-insurance are combined with your medical plan. If you receive behavioral health services prior to meeting your deductible, you may need to pay for these services up to the deductible amount before your plan starts paying. This does not apply to routine office visits for which you only pay an office visit copayment.

Benefits

Enrolled employees and their dependents have access to both in-network and out-of-network behavioral health benefits. However, you will pay more if you do not use a participating network provider and facility. This is known as balance billing. See the chart on this page for further details.

Support Services

The State of Ohio offers support services through the Ohio Employee Assistance Program (OEAP) for various behavioral health issues, which include behavioral health referrals and consultations for employees and their dependents. Other services include training, critical incident stress management, organizational transition interventions, mediation and a new Family Support Program for dependents up to age 26 who have a substance use problem. For details, visit *das.ohio.gov/behavioralhealth.*

BEHAVIORAL HEALTH BENEFIT PLAN	
Copayments	• Outpatient office visit in-network: $20
	• Outpatient office visit: out-of-network $30 (balance billing applies)
	• Intensive outpatient care in-network: $20
	• Intensive outpatient care out-of-network: $30 (balance billing applies)
Deductibles	• Single in-network: $250 combined with medical
	• Family in-network: $500 combined with medical
	• Single out-of-network: $500 combined with medical
	• Family out-of-network $1,000 combined with medical
Plan Coinsurance %	• Outpatient in-network: 100% after office visit copay, 80% for other services
	• Outpatient out-of-network: 60% of fee schedule after copayment (balance billing applies)
	• Inpatient in-network: 80% after deductible
	• Inpatient out-of-network: 60% after deductible, $350 penalty if not preauthorized
Out-Of-Pocket Maximum	• Single in-network: $1,500 combined with medical
	• Family in-network: $3,000 combined with medical
	• Single out-of-network: $3,000 combined with medical
	• Family out-of-network: $6,000 combined with medical
Other	• Day limits: None
	• Annual limits: None
	• Lifetime limits: None
	• Benefits limits: Some For details, visit *das.ohio.gov/behavioralhealth*, click the **Summary Plan Descriptions** tab and click the current summary plan.

Make Wellness Your Priority

LET *TAKE CHARGE! LIVE WELL!* BE YOUR GUIDE

Your health and wellness is important to us. The State of Ohio offers a robust and comprehensive health and wellness program called *Take Charge! Live Well!*

Take Charge! Live Well! provides the tools, guidance and resources you need to be healthier, happier and more productive, while reducing health care costs.

At an enterprise level, *Take Charge! Live Well!* is designed to:

- Offer preventive care tools and resources to its enrolled members and spouses;
- Increase productivity;
- Encourage engagement among employees and spouses;
- Improve retention; and
- Contain or reduce health care costs by improving health.

On a personal level, the benefits of *Take Charge! Live Well!* include:

- Biometric screenings;
- Well-Being 5 Survey;
- Health coaching;
- Rewards for taking steps to improve your health;
- 24-hour Nurse Advice Line;
- Flu vaccinations;
- Health and wellness fairs;
- Weight-loss, fitness and additional wellness challenges;
- A website full of resources, *ohio.gov/tclw*;
- On-site wellness ambassadors to provide information and answer questions; and
- Financial Well-Being program by financial expert Dave Ramsey.

Specific programs include:

- Tobacco cessation; and
- Support for chronic disease management.

Take Charge! Live Well! supports you in your effort to be your healthiest by helping you identify risks and improve your health.

Employees active in *Take Charge! Live Well!* appreciate the educational and motivational approach to health and wellness.

For full details, visit the *Take Charge! Live Well!* website at: *ohio.gov/tclw*.

WELLNESS REWARDS

Enrolled employees and spouses may earn up to $350 each by taking steps to improve their health.

Level 1: Assess Your Health	Point Value
Earn up to $150 per person in Level 1	
Biometric screening: • Complete an on-site screening; or • Submit the Physician Form, which is to be completed by your physician.	100 Points
Complete your Well-Being 5 survey.	50 Points

Level 2: Take Action	Point Value
Earn up to $200 in Level 2 Points can be earned by completing up to four total actions within the same activity or by combining actions with multiple activities.	
Coaching Calls	Earn 50 points for each completed coaching call, up to four calls.
Well-Being Challenges	Earn 50 points for each completed challenge, up to four challenges.
Financial Well-Being	Earn 50 points for each completed Financial Well-Being lesson, up to four lessons.

Reward cards are taxable compensation. Taxes are based on the amount of your reward and will be deducted from your paycheck.

For details about rewards and the *Take Charge! Live Well!* program, go to the *Take Charge! Live Well!* program website, *ohio.gov/tclw*, and click on the Program Guide button.

Healthways Website Updates Scheduled

Healthways will be performing annual system updates from July 1 through 17. During this time, Well-Being Connect will not be accessible.

Dental and Vision
FOR EXEMPT EMPLOYEES

The State of Ohio pays the full cost for you and your eligible dependents (children younger than age 23[1]) to participate in the dental and vision plans. Exempt employees are eligible to participate in these plans effective the first day of the month after completing one year of continuous state service. Employees are sent a letter indicating when they will be eligible for dental coverage.

Delta Dental PPO

Dental coverage is offered through the Delta Dental PPO plan, offered through Delta Dental of Ohio. You can go to any licensed dentist of your choice and receive benefits, but you typically will pay less when you go to an in-network dentist.

Your out-of-pocket expenses will vary depending on the participation status of your dentist. Your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of the Delta Dental networks. For most covered services, Delta Dental pays a higher percentage if you go to a dentist in its PPO network over its Premier network. Delta pays the least for out-of-network dentists.

To find a participating Delta Dental dentist near you, visit or call:

deltadentaloh.com
800-524-0149
Group Number: 9273-0001

Print Your Delta Dental Card Online
If you would like a card to present to your dentist, you may print a card from Delta Dental's website. After you are enrolled in the dental plan, visit *deltadentaloh.com* and click on **Consumer Toolkit**.

Complete the login process and click on **Print ID Card**. If you are enrolling in the plan for the first time, please wait until July 1 to access the dental site.

Vision Service Plan

Vision coverage is offered through Vision Service Plan (VSP). The VSP Choice network encompasses a large number of providers. If you use a non-network provider, out-of-network charges will apply.

To find a participating VSP vision provider near you, visit or call:

vsp.com
800-877-7195
Group Number: 12022518

Print Your VSP Card Online
If you would like an enrollment card to present to your vision provider, you may print a card through the VSP website. After you are enrolled in the vision plan, visit *vsp.com*, complete the login process and click on **My Member Vision Card**. If you are enrolling in the vision plan for the first time, wait until July 1 to access the site.

See Page 15 to view the in-network and out-of-network benefits for the dental and vision plans.

[1] View detailed eligibility and documentation requirements at: *das.ohio.gov/EligibilityRequirements.*

UNION BENEFITS TRUST

For Union-Represented Employees

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT).

The UBT Enrollment Guide will be mailed to union members' homes. The guide includes enrollment/change forms for dental, vision and legal plans. For supplemental life insurance, a separate mailing from Prudential will arrive during the same period. For more information, please visit *benefitstrust.org*.

DELTA DENTAL PLAN FOR EXEMPT EMPLOYEES

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist*
Annual Maximum	$1,500	$1,500	$1,500*
Diagnostic and Preventive Services	100%	100%	100%*
Basic Restorative Services (e.g., filling)	100%	65%	65%*
Major Restorative Services (e.g., crown, bridge)	60%	50%	50%*
Orthodontia	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum	50% up to $1,500* lifetime maximum

Deductible – $25 deductible per person total per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, periodontal maintenance (cleaning) and orthodontic services.

There is a separate $1,000 lifetime maximum on dental implants.

*Delta Dental will pay up to the allowed amount or the maximum allowable charge for providers in your area. You can be balance billed by non-Delta Dental providers for any amount that exceeds the allowable amount. Network providers cannot balance bill you for the difference between their charge and Delta Dental's allowed amount.

VISION SERVICE PLAN (VSP) FOR EXEMPT EMPLOYEES

Service	In-Network	Out-Of-Network
Routine Exam/Frame/Lens Frequency	1 every 12 months	
Routine Exam/Professional Fees	Plan pays 100% after $10 copy.	You pay $10 copy, then plan pays maximum of $25.
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.
MATERIALS/LENSES Single Vision Lenses Bifocal Lenses Progressive Lenses Trifocal Lenses Lenticular Lenses Polycarbonate Lenses	Plan pays 100% after $15 copy.	You pay $15 copy, then plan pays maximum benefit of: $25 $35 $52 $52 $62 $0
CONTACT LENSES Elective (Instead of Lenses and Frame)	Plan pays maximum of $125 plus standard eye exam.	
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of $125 plus standard eye exam.

Life Insurance
FOR EXEMPT EMPLOYEES

Exempt Basic Life Insurance

The State of Ohio pays the cost for eligible exempt employees to participate in the basic life plan. Eligible exempt employees are automatically enrolled in the basic life plan after one year of continuous state service. The coverage includes an accidental death and dismemberment benefit for work-related injuries. This benefit – equal to your annualized rate of pay rounded to the next highest $1,000 – is provided to you at no cost.

The Internal Revenue Service (IRS) requires that employees be taxed on the value of employer-paid group life insurance coverage exceeding $50,000. This is known as "imputed income." If your annualized rate of pay (and thus your group life insurance) exceeds $50,000 per year, the tax you owe on the value of the coverage that exceeds $50,000 is reported to the IRS in Box 12 of your year-end W-2 form. The tax is based upon employee age brackets on the last day of the calendar year and increases in five-year increments as you grow older. See the imputed income rate chart on the right.

IRS BASIC LIFE IMPUTED INCOME CHART
(Monthly Cost Per $1,000 of Coverage in Excess of $50,000)

AGE	COSTS
Younger than 25	$0.05
25 through 29	$0.06
30 through 34	$0.08
35 through 39	$0.09
40 through 44	$0.10
45 through 49	$0.15
50 through 54	$0.23
55 through 59	$0.43
60 through 64	$0.66
65 through 69	$1.27
70 and older	$2.06

Beneficiary Forms

You may designate one or more beneficiaries for your basic and supplemental life benefits by visiting the Minnesota Life, a Securian company, website at lifebenefits.com. For logon instructions, see Page 17 under Life Insurance for exempt employees. Or you may submit a beneficiary form by mail to Minnesota Life. This form is available in the forms section of the DAS Benefits Administration website, located at *das.ohio.gov/HealthPlanForms*. Your beneficiary elections will apply to both your basic and supplemental life insurance benefits.

Exempt Supplemental Life Insurance

Exempt employees are eligible to purchase supplemental life insurance coverage, provided by Minnesota Life. This coverage is entirely employee-paid, and can be purchased within 90 days of employment or upon becoming an exempt employee with no waiting period. When you enroll for coverage, you also may elect life insurance for your eligible dependents. The amount you contribute toward your supplemental and dependent life coverage is deducted from your paycheck. See Page 17 for plan contact information and initial logon credentials.

For Yourself

At Open Enrollment, if you do not already have supplemental life coverage, you may purchase up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability. If you have existing coverage, you may increase coverage by up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability.

The maximum amount of coverage available is the lesser of eight times your annualized earnings or $600,000. If your coverage election exceeds the non-medical limits described above, evidence of insurability will be required. Coverage above the non-medical limits will become effective once evidence of insurability is approved by Minnesota Life. Outside of Open Enrollment, supplemental life coverage may not be increased without a qualifying life event. If you experience a qualifying life event, you must submit your request within 31 days of the associated life event. For questions regarding a qualifying life event, call Minnesota Life. See Page 17 for contact information.

For Your Spouse

You may purchase supplemental life insurance for your spouse in $10,000 increments up to $40,000. Spousal coverage in excess of $10,000 requires your spouse to provide evidence of insurability.

For Your Dependent Children

You may purchase $7,000 of life coverage for each of your eligible dependent children younger than age 26 at a rate of $0.82 cents per month, regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 26.

Cancelling or Reducing Coverage

You may cancel or reduce your employee or dependent supplemental life insurance coverage at any time throughout the year by submitting a written request to Minnesota Life. Coverage will be cancelled or reduced effective the first of the month after your request is received and processed by Minnesota Life. Once coverage is cancelled or reduced for either yourself and/or your dependents, evidence of insurability will be required for any future enrollment for supplemental life coverage, including during Open Enrollment and qualifying life events. You may be required to submit medical documentation and your coverage election may be approved or rejected by Minnesota Life based upon medical underwriting results.

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Aetna
800-949-3104
aetnastateohioemployee.com
Group Number: 285507

Anthem
844-891-8359
enrollment.anthem.com/stateofohio
Group Number: 004007521

Medical Mutual of Ohio
800-822-1152
stateofohio.medmutual.com
Group Number: 228000

Prescription Drug
OptumRx
866-854-8850
OptumRx.com
Rx Group Number: STOH

Behavioral Health and Substance Use
Optum Behavioral Solutions
800-852-1091
liveandworkwell.com
Website Access Code: 00832

Ohio Employee Assistance Program
800-221-6327
ohio.gov/eap

Take Charge! Live Well!
Healthways
866-556-2288
ohio.gov/tclw
Click the Healthways website button.

24-Hour Nurse Advice Line
Healthways
866-556-2288, option 1

Flexible Spending Accounts and Commuter Choice
WageWorks
855-428-0446
wageworks.com

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
800-524-0149
deltadentaloh.com
Delta Dental PPO
Group Number: 9273-0001

Vision
Vision Service Plan (VSP)
800-877-7195
vsp.com
Group Number: 12022518

Life Insurance
Basic Life Insurance and Supplemental Life Insurance
Minnesota Life, a Securian company
866-293-6047
lifebenefits.com
Group Number: 34301
Initial logon credentials for life insurance: The initial user ID is "**OH**" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security number.

Ohio Department of Administrative Services

HR Customer Service

614-466-8857 (option 2) or
800-409-1205 (option 2)

email: *HRCustomerService@das.ohio.gov*

website: *das.ohio.gov/benefits*

TIP:

When placing a call, please ensure you have the documentation you might need during the call:

- Group Number
- State of Ohio User ID
- Explanation of Benefits if call is regarding a claim.

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614-508-2255
800-228-5088
benefitstrust.org

The websites of the Union Benefits Trust (UBT) vendors listed below can be accessed through the UBT website.

Dental
Delta Dental of Ohio
877-334-5008
Group Number: 1009

Vision
Vision Service Plan (VSP)
800-877-7195
Group Number: 12022914

EyeMed Vision Care
866-723-0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
800-778-3827
Group Number: LG-01049

Work/Life Program
Working Solutions Program
800-358-8515
Group Number: 4718

Legal Services
Hyatt Legal Services
800-821-6400
Group Number: 4900010

UNION BENEFITS TRUST

Legal Notices

State of Ohio
Employee Health Plans
30 E. Broad St., 27th Floor
Columbus, Ohio 43215

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the privacy practices of the State of Ohio's self-funded medical plans, prescription drug plan, behavioral health plan, population health management plan, dental plans, vision plans, flexible spending account (but not dependent care flexible spending account) which are administered by the State of Ohio, Department of Administrative Services, Office of Benefits Administration Services (collectively "the Plan"). The Plan is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information (PHI), and to provide individuals with notice of the legal duties and privacy practices with respect to protected health information and to abide by the terms of the notice currently in effect.

Position on Privacy

The Plan is committed to maintaining the privacy of its enrolled persons. As part of your participation in the health plans, the Plan and its business associates (whom we use to administer and deliver health care services) receive health information through the operation and administration of the plans. PHI refers to any information, transmitted or maintained in any form or medium, which the Plan creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services that identifies you or could reasonably be used to identify you. PHI and other Plan records are maintained in compliance with applicable state and federal laws.

If you have questions about this notice, please contact the Plan's HIPAA Privacy Contact listed on Page 20.

How the Plan May Use or Disclose Your Protected Health Information

The Plan may only use or disclose your medical information as described in this notice. Not every authorized use or disclosure in each category is listed, however all permitted uses and disclosures fall into one of these general categories.

1. Uses and Disclosures of Your PHI for Treatment, Payment, and Health Care Operations

For Treatment. The Plan may make requests, uses, and disclosures of your PHI as necessary for treatment purposes. For example, the Plan may make disclosures to your health plan regarding eligibility, or make disclosures to health care professionals involved in your care.

For Payment. The Plan may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, the Plan may use information regarding your medical procedures and treatment so the third party administrator can process and pay claims. The Plan may also disclose your PHI for the payment purposes of a health care provider or a health plan.

For Health Care Operations Purposes. The Plan may use and disclose your PHI as necessary for health care operations. For example, Health Care Operations include, but are not limited to, use and disclosures: by health plan of PHI to the Plan for administration of the health plans; for quality assessment of the plans through the distribution and analysis of satisfaction surveys; in connection with the performance of disease management functions; and for general administrative activities, including customer service, cost management, data management, communications, claims and operational audits, and legal services. In addition, a health plan may send you information based on your own health information to inform you of possible treatment options or alternatives that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

2. Other Uses and Disclosures of PHI for Which Your Authorization is Not Required

In limited instances, the law allows the Plan to use and disclose your PHI without your authorization in the following situations:

A. **As Required By Law.** The Plan may disclose your PHI when required by federal, state or local law.

B. **Family and Individuals Involved in Your Care.** The Plan may disclose medical information about you to a family member or friend who is involved in your medical care. The Plan may request that your family members verify their identity and demonstrate they are acting on your behalf.

C. **To Avert a Serious Threat to Health or Safety.** The Plan may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

D. **Public Health Activities.** The Plan may use and disclose medical information about you for public health activities including activities related to preventing and controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

E. **Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.

F. **Health Oversight Activities.** The Plan may disclose medical information to a health oversight agency for oversight activities authorized by law, such as: overall health care system monitoring, monitoring the conduct of government programs, and monitoring to ensure compliance with civil rights laws.

G. **Lawsuits/Legal Disputes.** The Plan may use and disclose medical information about you in the course of an administrative or judicial proceeding, such as in response

to a subpoena, discovery request, warrant, or a lawful court order.

H. **Law Enforcement Purposes.** The Plan may disclose medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.

I. **Specialized Government Functions.** The Plan may disclose medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

J. **Military.** If you are a member of the armed forces, the Plan may disclose medical information about you as required by military command authorities.

K. **Organ, Eye and Tissue Donation.** If you are an organ donor, the Plan may disclose information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

L. **Workers' Compensation.** The Plan may disclose medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

M. **Coroners, Medical Examiners, and Funeral Directors.** The Plan may disclose medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also disclose medical information about patients to funeral directors as necessary to carry out their duties.

N. **Business Associates.** The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may use and disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

O. **Disclosure to You.** The Plan may disclose your medical information to you.

3. Other Uses and Disclosures of PHI Requiring Your Written Authorization

In all situations other than those described previously, the Plan will ask for your written authorization before using or disclosing your PHI. For example, (except as required or permitted by law), the Plan will not use or disclose psychotherapy notes or sell your medical information without obtaining your prior written authorization. If you have provided authorization, you may revoke it in writing at any time, unless the Plan has already disclosed the information.

4. Changes to Existing Laws

Certain provisions of Ohio law may impose greater restrictions on uses and/or disclosures of PHI, or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this notice, the Plan must comply with those provisions.

Your Legal Rights

Federal privacy regulations provide you the following rights associated with your medical information:

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received.) **The Plan is not required to agree to your request.** To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. In your request, you must explain: (1) what PHI you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and, (3) to whom you want the limits to apply (for example, your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at a specific phone number or address. To request confidential communications, you must make your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. After the Plan receives your request, the information may be forwarded to your health plan. As a result, additional reasonable information may be required from you by your plan to process the request.

Right to Inspect and Copy Your Information. You have the right, in most cases, to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other unusual supplies associated with your request. Under Ohio and federal law, the Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Request an Amendment. If you feel that medical information about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Plan's HIPAA Privacy Contact listed on this page. You must provide reasons that support your request. If the Plan denies your request for any reason under state or federal law, the Plan will permit you to submit a written statement of disagreement to be kept with your PHI. The Plan may reasonably limit the length of such statement of disagreement.

Legal Notices

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures the Plan has made of medical information about you. This accounting will not include many routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan's HIPAA Privacy Contact. Your request must state the time period that may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice even if you have received it electronically. You may make your request to the Plan's HIPAA Privacy Contact.

Right to Breach Notification. You have the right to notification if a breach of your unsecured PHI has occurred.

This Notice Is Subject To Change

The Plan reserves the right to change the terms of this notice and its privacy practices at any time. If such a change is made, the new terms and policies will be effective for all of the information that the Plan has about you as well as any information it may hold about you in the future, and will be posted at das.ohio.gov and may be provided by mail if required. If you want to ensure you have the latest version of this notice, you may contact the Plan's HIPAA Privacy Contact.

Whom to Contact

If you believe your privacy rights have been violated, you may file a complaint with the Plan's HIPAA Privacy Contact or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact the

Office of Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601.

Complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Questions regarding this Notice may be directed to the Plan's HIPAA Privacy Contact:

DAS -- HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, Ohio 43215

614-466-6205; email: *gregory.pawlack@das.ohio.gov*

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

What is COBRA Continuation Coverage?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Legal Notices

**If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee's period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee's dependent.*

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employees is becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Each covered person will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Legal Notices

California State Residence: Under California law, you may be eligible for a state-mandated extension of benefits after your federally-mandated COBRA period expires. California state laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to qualified beneficiaries who begin COBRA coverage on or after Jan. 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to Pre-Existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rules with these new limits as follows:

- If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.
- You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

If You Have Questions

This notice does not fully describe continuation coverage or other rights under the Plan. More complete information regarding such rights is available from the plan contact identified on Page 20 and throughout the Summary Plan Description. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified on Page 20. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.) For more information about the Marketplace, visit *www.Healthcare.gov*.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA contact information

If you have any questions about your rights to COBRA continuation coverage, you should contact:

Legal Notices

Through June 30, 2017:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252

Customer Care Center
Toll Free: (877) 237-8576
email: *cobra_kyoperations@uhc.com*
www.uhcservices.com

Beginning July 1, 2017:
Visit das.ohio.gov/cobra for contact information.

SPECIAL ENROLLMENT RIGHTS PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance or group health plan coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of such an event.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at 312-353-0900.

If you have questions about this notice, please contact your Plan Administrator listed below:

State of Ohio
Department of Administrative Services
Benefits Administration Services
Medical Plan Benefits Manager

30 East Broad Street, 27th Floor
Columbus, Ohio 43215
(800) 409-1205 (option 2)

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. The terms of WHCRA provide:

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and,
4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions or would like more information about the State of Ohio's WHCRA benefits, contact HR Customer Service at 614-466-8857 (option 2) or 800-409-1205 (option 2).

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under the provisions of The Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PATIENT PROTECTION DISCLOSURE

The Ohio Med PPO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please see the contact numbers below for Aetna, Anthem, and Medical Mutual of Ohio.

Legal Notices

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna, Anthem, Medical Mutual of Ohio, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact: Aetna at (1-800-949-3104); Anthem at (1-844-891-8359); or, Medical Mutual of Ohio at (1-800-822-1152).

CREDITABLE COVERAGE DISCLOSURE:

Important Notice from the State of Ohio About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Ohio and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The State of Ohio has determined that the prescription drug coverage offered by OptumRx is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current State of Ohio coverage will not be affected. The State of Ohio has determined that the prescription drug coverage offered by OptumRx is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Go to: *das.ohio.gov/prescriptiondrug* for more details on your prescription benefits.

If you decide to join a Medicare Drug Plan and drop your current state medical coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualifying event or sign up during Open Enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the State of Ohio and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For further information, contact:

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Prescription Drug Benefits Manager

30 East Broad, 27th Floor
Columbus, OH 43215
800-409-1205 (option 2)

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Ohio changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Legal Notices

For more information about Medicare prescription drug coverage:

- Visit: *medicare.gov*.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at: *socialsecurity.gov* or call them at 1-800-772-1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NOTICE REGARDING WELLNESS PROGRAM

Take Charge! Live Well! is a voluntary wellness program available to all employees enrolled in the State of Ohio medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You also will be asked to complete a biometric screening, which will include a blood test for total cholesterol, high density lipoprotein (HDL), low density lipoprotein (LDL), triglycerides, and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $50 for completion of the HRA and $100 for completion of a biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to $200 may be available for employees who participate in certain health-related activities such as health coaching and online participation in health and wellness lessons and/or challenges. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation. You may request a reasonable accommodation by contacting Beth Kim, State of Ohio Wellness program manager, at 614-728-5478.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and QuitNet. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Ohio may use aggregate information it collects to design a program based on identified health risks in the workplace, *Take Charge! Live Well!* will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the health coaching staff at Healthways, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Beth Kim at 614-728-5478.

PLEASE NOTE: The material in this publication is for informational purposes. It is intended only to highlight the main benefits, eligibility policies and coverage information for State of Ohio employees and their dependents. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the plan documents, the plan documents govern. To locate the plan documents on the Benefits Administration website, *das.ohio.gov/benefits*, click on Medical located in the right navigation pane under Benefits.

Glossary

When reviewing information about your health care coverage options, it is helpful to understand some of the basic terms and concepts.

Benefit Year/Plan Year: The 12-month period from July 1 through June 30 during which services are rendered and your deductible and coinsurance are accumulated.

Biometric Screening: A private screening with a health professional that provides a snapshot of your health. The screening includes cholesterol (total), HDL, LDL, blood glucose, blood pressure, height, weight and waist circumference.

Change in Status/Qualifying Event: A change in your life that allows you to enroll or make an adjustment to your existing coverage. Examples include marriage, divorce, birth or adoption of a child, or a change in job status for you or a dependent.

Coinsurance: The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, an 80 percent coinsurance rate means you pay 20 percent and the plan pays 80 percent.

Copay: A specified dollar amount you pay to a health care provider or pharmacy for eligible expenses such as office visits and prescriptions. Copays do not count toward your annual deductible.

Covered Person: The employee, the employee's spouse and/or dependent children who are eligible and enrolled under your health care plan.

Covered Services: Those services and supplies provided for the purpose of preventing, diagnosing or treating a medical condition, behavioral disorder, psychological injury or substance use addiction for which the plan will provide benefits.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything. This does not apply to preventive services covered at 100 percent.

Dependent(s): A spouse and/or an eligible child or children.

Eligible Expense: The maximum amount on which payment is based for covered health care services. You may be required to pay a percentage of Eligible Expenses in the form of Coinsurance.

Employee Share or Contribution: The portion of the total premium that you pay through pre-tax payroll deductions for your coverage.

Exempt Employee: An appointment to a position not represented by a labor union. Employees are usually exempt from union representation because they are supervisors, in positions of a confidential or fiduciary nature or not in permanent appointments.

Flexible Spending Accounts (FSA): A type of savings account that provides the account holder with specific tax advantages. The account allows employees to contribute a portion of his or her regular earnings to pay for qualified expenses, such as for medical or dependent care. The two types of FSAs are health care spending accounts and dependent care spending accounts.

Out-of-pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the plan year. After your out-of-pocket expenses reach the maximum, the plan pays 100 percent of any additional eligible expenses for the remainder of the plan year. There is a separate out-of-pocket maximum for prescription drugs.

Patient Protection and Affordable Care Act (also known as the Affordable Care Act or PPACA or simply ACA): The health reform legislation passed by Congress and signed into law in March 2010 by the president of the United States.

Preferred Provider Organization (PPO): A PPO is a medical plan that offers benefits at both network and non-network levels. When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the benefit is greater when you use network providers, but less when you use providers who are not part of the network.

State Share or Contribution: The portion of the total premium the State of Ohio pays to provide its employees with coverage.

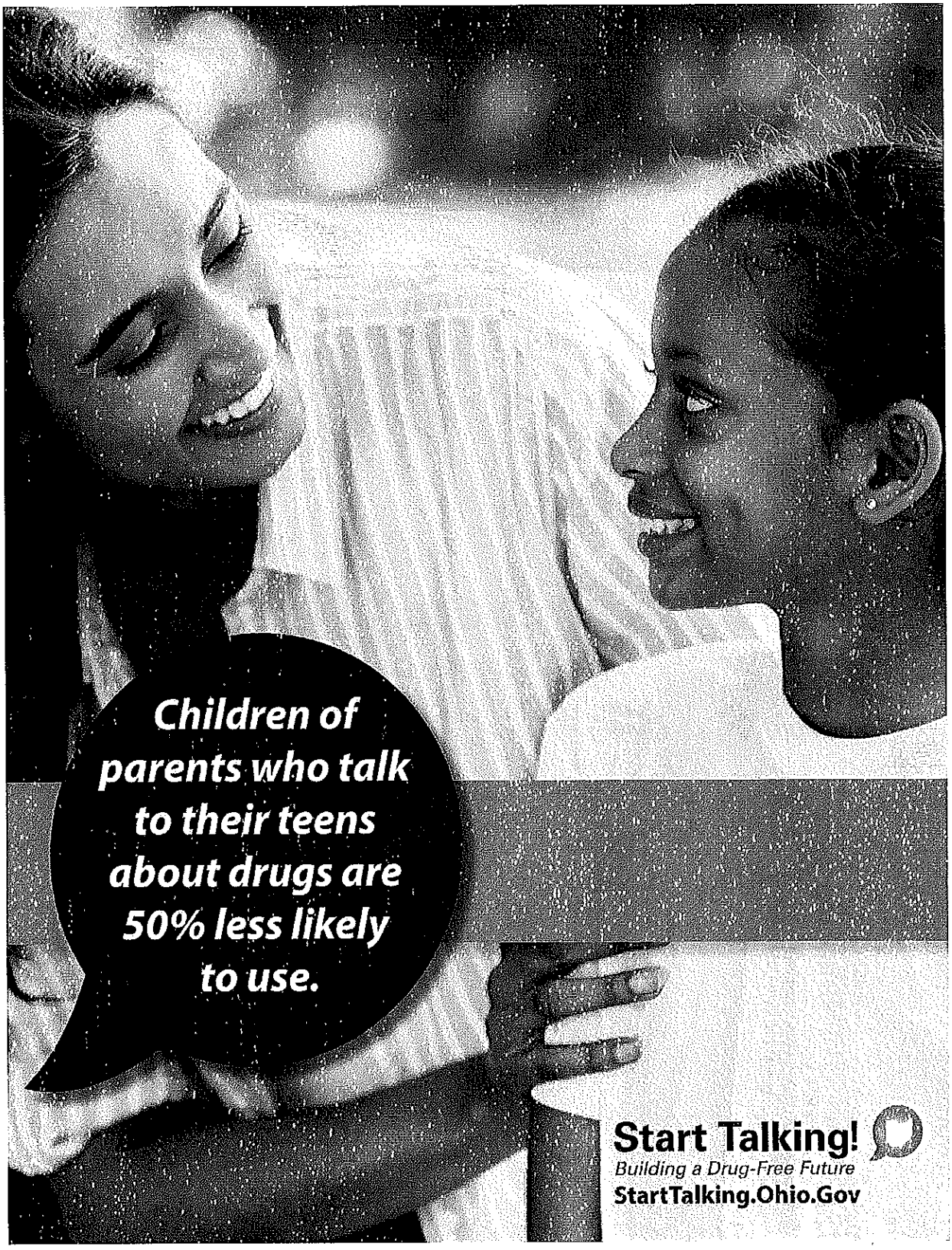
Summary of Benefits and Coverage (SBC): A requirement of the Patient Protection and Affordable Care Act, the SBC is a concise four-page document that details simple and consistent information about health plan benefits and coverage. It will help you understand the basics of your coverage and allow you to compare any different coverage options you may have. It summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and limitations and exceptions. All insurance companies and group health plans must use the same standard SBC form. The SBC also contains a link to the required Uniform Glossary, which provides definitions of many commonly used health coverage and medical terms. For full details, visit das.ohio.gov/benefits.

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer. For example, Aetna, Anthem and Medical Mutual are the third-party administrators of the Ohio Med PPO.

Total Premium: The combination of the employee contribution and the state contribution.

Union-Represented Employee: Also known as a Bargaining Unit Employee, is represented by a labor union and covered by the terms of a collective bargaining agreement.

Well-Being 5 Survey: A confidential questionnaire that assesses your physical, emotional, financial and social health and how your lifestyle habits affect your overall well-being.


Children of parents who talk to their teens about drugs are 50% less likely to use.
Start Talking!
Building a Drug-Free Future
StartTalking.Ohio.Gov

OhioDAS
SERVICE · SUPPORT · SOLUTIONS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Ohio Department of Administrative Services
Human Resources Division
30 E. Broad St., 28th Floor
Columbus, Ohio 43215

Open Enrollment 2017

MAY 15 THROUGH MAY 26, 2017

(EFFECTIVE JULY 1, 2017 THROUGH JUNE 30, 2018)

Ohio Med PPO Plan

- Three administrators will manage the Ohio Med PPO plan
  - Aetna
  - Anthem
  - Medical Mutual
  - The rate will be the same for all administrators
  - Employees will automatically be assigned to the correct administrator

Important Administrator Highlights

- Employee contributions- 'Family w/Spouse', 'Family w/o Spouse', and 'Single' rates will be the same with all administrators

- Major benefit levels- Co-pays, deductibles, and out-of-pocket maximums will be the same with all administrators